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ABSTRACT

This document present witnesses' testimonies from the Congressional hearing called to examine condom advertising and Acquired Immune Deficiency Syndrome (AIDS). Opening statements are included by Congressmen Henry Waxman, William Dannemeyer, and Jim Bates. C. Everett Koop, United States Surgeon General, and Gary Noble, AIDS coordinator for the Public Health Service, discuss the use of condoms in reducing the spread of AIDS, cite research testing condom effectiveness, and advocate condom advertising on television. June E. Osborn, dean of the School of Public Health, University of Michigan, describes condom usage as one of the few effective means available to prevent viral transmission and supports condom advertisements on television. Also testifying are representatives of the three national television networks: (1) Ralph Daniels, National Broadcasting Company; (2) George Dessart, Columbia Broadcasting System; and (3) Alfred R. Schneider, American Broadcasting Company. These witnesses describe efforts their companies have taken in AIDS education through programming and public service announcements and explain the problems associated with paid advertising of condoms. Theresa L. Crenshaw, president of the American Association of Sex Educators, Counselors, and Therapists, and Michael J. Rosenberg, executive director of the American Social Health Association, give their views on condom effectiveness, condom advertising, and the need for public education about AIDS. Materials submitted for the record are included as are question and answer dialogues between committee members and witnesses. (NB)

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CONDOM ADVERTISING AND AIDS

ED289099

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

FEBRUARY 10, 1987

Serial No. 100–1

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CONDOM ADVERTISING AND AIDS

TUESDAY, FEBRUARY 10, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:52 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

The statistics of the AIDS epidemic are becoming horribly familiar to all Americans; 30,000 cases to date in the United States; 17,000 deaths. Within 4 years, 270,000 cases and 180,000 deaths, three times the American fatalities in the war in Vietnam.

The disease is transmitted principally by sex, by what has been coyly referred to as "the exchange of bodily fluids," that is, by anal, oral and vaginal intercourse. There are two ways to be certain of stopping this transmission: safe sex or no sex.

"Safe sex" is sexual contact without intercourse. No fluid is exchanged between partners, but such sexual practices are not common in America.

"No sex" will stop the AIDS transmission—but if VD and unwanted pregnancy rates are any example—abstinence, while preached for centuries, may be at an all time low in America.

In the face of the limitations of these two alternatives, the professionals of medicine and public health have turned to the next best choice: condoms.

Condoms are perhaps the world's oldest medical device. They have lowered the transmission of disease for hundreds of years. While they are not fail proof, they represent our best hope for a widely acceptable means of slowing this newest epidemic.

Condoms have been advocated by many experts: the Surgeon General of the U.S. Public Health Service, who will testify before us this morning; the Institute of Medicine of the National Academy of Sciences; and almost every medical and public health group in America. But information regarding condoms and AIDS has been restricted by the largest and most effective communications medium in America—television.

The routine promotion of condoms through advertising has been stopped by networks who are so hypocritically priggish that they refuse to describe disease control as they promote disease transmission. While portraying thousands of sexual encounters each year in programming and while marketing thousands of products using sex

appeal, television is unwilling to give the life saving information about safe sex and condoms.

We cannot afford such selective prudishness. Television networks cannot continue to pretend that this public health crisis is limited and that their viewers do not need to know about preventive measures.

If doctors had withheld penicillin from syphilis patients because they might have encouraged extramarital sex, we would have recognized that as medical malpractice.

In the same fashion, the networks' continued refusal to allow condom advertising is media malpractice. At this point, information is our only defense in the war on AIDS. Television has a responsibility to help fight this war. Without all assistance, the nation faces a larger epidemic with more cases and more deaths.

Before calling on our witnesses, I want to recognize the members of the Subcommittee who wish to make an opening statement. I recognize Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you, Mr. Chairman. I appreciate your opening comments and your holding this hearing today.

I think there was a mistake in your opening statement. I thought I heard you say 20,000 cases so far. There have been about 30,000. I think it was just an innocent oversight.

There is a suggestion that some have sought to foster in this country that if we can only get the American people to use condoms, we can stop the spread of AIDS. I am here to suggest this morning, and I'm grateful for the opportunity to listen to the witnesses, to suggest that if anyone says that to the people of this Nation, they are causing a delusion. That statement is only partially true.

The evidence is very clear that it is fair to say that the main means of transmissibility of AIDS, and the virus for AIDS, is sex and intravenous drug uses. That is not the only means. It may be socially transmitted, although there have been only a few cases in the literature where that has been the case.

For example, The Lancet, September 20, 1986 reported a young boy of about five who contacted AIDS from a blood transfusion and later died. Testing on other family members revealed a brother three years older who was positive for the AIDS virus. The mother related that about six months before the older boy died, she had seen teeth marks on the shin of the older boy but no bleeding. The logical explanation is horizontal transmission.

Dr. Robert Gallo, co-discoverer of HTLV-III states in the December 29, 1984 issue of The Lancet, "saliva was indeed the mode of AIDS transmission from a man with transfusion associated AIDS to his wife. She yielded infectious HTLV-III in her peripheral blood lymphocytes and saliva." This study was published in the AMA Medical News, November 22-29, 1985 at page 2867.

In Florida, the Institute of Tropical Medicine Workers feel strongly that mosquitoes can transmit AIDS because in Belle Glade, Florida, numerous cases are being reported that are not in the high-risk category.

Two health care workers who normally would not be considered at risk for AIDS contracted the disease after coming into contact with blood at their workplace. One of the women died.

Cory Servaas, an epidemic intelligence officer for the U.S. Centers for Disease Control in Atlanta, said, "you can't say it definitely was blood but there is certainly a question of it." This was reported in the Associated Press, September 18, 1985.

The evidence is clear that condoms have a 50 percent failure rate on anal intercourse. They have a 10 percent failure rate on vaginal intercourse. If we are saying to the American people that condoms can make all of us safe from AIDS, we are fostering a delusion in this country.

I want to commend Dr. Koop for the excellent statement that he and Mr. Bennett, Secretary of Education, put forth on January 30, 1987; one page in length. It was an excellent statement insofar as it went. I think it would be appropriate to quote from just one portion of it.

"With regard to AIDS, science and morality teach the same lesson. The best way to avoid AIDS is a mutually faithful monogamous sexual relationship. Until it is possible to establish such a relationship, abstinence is the safest."

Dr. Koop, I commend you for that statement. There is only one word that I would have preferred you add to that, and it really is an interesting observation with respect to the status of our society today, where you as the chief health officer of the United States Government would have not included the word "heterosexual sexual relationship" in that statement. I think that is the statement that we should be saying to the people of this country. That is the foundation of our civilization.

I thank you, Mr. Chairman, for this opportunity to make this opening statement.

Mr. WAXMAN. Thank you, Mr. Dannemeyer. Mr. Bates.

Mr. BATES. Thank you, Mr. Chairman. I have just a brief statement. I wanted to thank you for holding these hearings and I think that hopefully they will be but the beginning in a series of hearings that I think need to be held on the whole range of issues related to the AIDS epidemic.

The research aspects, which I think are faltering, the testing that needs to be done. In the Armed Services, I think an improvement in making available to patients in the Armed Services the same drugs on an experimental basis that are now available to the population at large.

With respect to condom advertising through the media, I think as much information as possible through this hearing and through other avenues particularly television, which seems to be where many people get their information, I think we do need to encourage the dissemination of as much information as possible.

With respect to the failure rate of the condoms, I think 50 percent is better than zero percent. I think it has clearly shown that it is a numbers game in terms of how we can try to control this serious health hazard.

I would just commend you for holding these hearings. I am pleased to see the witnesses here today, particularly Dr. Everett Koop, Surgeon General, who I want to commend publicly for speaking out on this issue. Anyone in public life realizes you cannot satisfy all your critics. I think you are doing an excellent job of getting this issue before the American public.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Bates.

Our first witness at today's hearing is the Surgeon General of the United States, Dr. C. Everett Koop. Dr. Koop represents the administration on various issues relating to AIDS and has recently authored a major Government report on the disease.

Dr. Koop, we want to welcome you to our subcommittee hearing today. We have your prepared statement and we will make that part of the record in full. We would like to call upon you to summarize that statement in 5 minutes and then we will have gone questions.

STATEMENT OF C. EVERETT KOOP, SURGEON GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY GARY NOBLE, AIDS COORDINATOR, PUBLIC HEALTH SERVICE

Mr. KOOP. Mr. Chairman, I am C. Everett Koop, a medical doctor and the Surgeon General for the Public Health Service. I appear before this subcommittee to discuss the use of condoms in reducing the spread of Acquired Immune Deficiency Syndrome.

Scientific evidence indicates that abstinence is the only completely safe way to avoid acquiring AIDS sexually. Except for mutually faithful monogamous relationships with uninfected partners, the use of a condom is the best method of reducing or slowing the HIV infection known at this time for those who for one reason or another will not practice abstinence or monogamy.

Since January of 1985, the Public Health Service has been recommending the use of condoms as an effective means of preventing or reducing the transmission of AIDS in sexually active individuals. It is recognized that condoms sometimes fail. For example, it has been shown that condoms may have a failure rate of 10 percent when used as a contraceptive.

A condom must be properly used if it is to help prevent transmission of the AIDS virus. That is why I stressed in the Surgeon General's Report on AIDS that a condom must be used from start to finish.

In my report of October, 1986, I state "if your blood test for antibody to the AIDS virus is positive or if you engage in high risk activities and choose not to have a test, you should tell your sexual partner. If you jointly decide to have sex, you must protect your partner by always using a condom during sexual intercourse."

I also said "If your partner has a positive blood test showing that he or she has been infected with the AIDS virus or you suspect that he or she has been exposed by previous heterosexual or homosexual behavior or the use of I.V. drugs with shared needles and syringes, a condom should always be used during sexual intercourse."

Condoms, Mr. Chairman, are manufactured from latex or natural membranes and when used properly, prevent both semen deposition and contact with urethral discharge or mucous membranes.

HIV, hepatitis B, cytomegalovirus, gonorrhea, chlamydia, mycoplasma and trichomonal organisms are all transmitted in semen or vaginal secretions and a condom can reduce the rate of infection.

Electron microscopic studies have shown that properly manufactured latex condoms are a continuous layer with no holes. Quality procedure controls performed by condom manufacturers are stringent and every condom is tested for holes.

Condoms made from natural animal membranes contain tiny pores which have been shown to allow passage of extremely small particles. However, all known infectious sexually transmitted agents are at least twice the size of those pores.

Under conditions simulating the mechanical friction of vaginal intercourse, latex and natural membrane condoms have been shown to be an effective barrier to HIV and other infectious agents, but caution should be used in extrapolating these limited laboratory studies to actual use.

Some studies clinically support the laboratory studies just mentioned. A cohort study followed condom users over time and showed they were less likely than non-users to acquire gonorrhea. A recent cohort study in the United States which followed heterosexual spouses of persons with AIDS for one to three years, found that seroconversion to HIV antibody positive was associated with lack of regular condom use.

In a third study, prostitutes in Zaire, whose clients consistently used condoms, had significantly lower rates of HIV infection than prostitutes whose clients did not use condoms.

Several studies are now underway, Mr. Chairman, to determine the degree to which condoms and other barrier methods of contraception are effective in reducing the risk of HIV transmission.

In summary, condoms have been shown to obstruct the passage of the AIDS virus under specific laboratory conditions. The clinical studies I have cited lend support to these findings in actual practice. The use of condoms has limitations, but they are an integral part of our overall strategy to reduce the spread of the AIDS virus.

That concludes my testimony, Mr. Chairman. My colleague, Dr. Noble, and I will be pleased to answer your questions.

Mr. WAXMAN. Thank you very much, Dr. Koop. I welcome you also, Dr. Noble, to our subcommittee hearings.

Dr. Koop, do you support the advertising of condoms on television?

Mr. KOOP. Sir, the threat of AIDS is so great that it overwhelms other considerations, and advertising, I think, therefore is necessary in reference to condoms and would have a positive public health benefit.

Mr. WAXMAN. Let me ask you about the issue of the failure rate of condoms that has been referred to in comments made earlier today. What is the estimated failure rate for use of condoms?

Mr. KOOP. The one that I gave you was one commonly used, sir, less than 10 percent. Dr. Noble has investigated this very thoroughly and I would rather have him answer that for you, please.

Mr. WAXMAN. Dr. Noble.

Mr. NOBLE. Many studies have been done to look at the effectiveness of the condom in preventing conception. The general figure which has been used is 10 percent, as Dr. Koop mentioned. However, in carefully controlled studies where the practice of the condom use is ideal, the failure rate is only 2 to 4 percent. It points out

that the product is very good and the greater part of the failure resides in how the condom is used.

The condom has also, of course, been shown to be effective in the prevention of various sexually transmitted diseases, as Dr. Koop mentioned. These studies also vary considerably.

Condoms alone can reduce the infection rate of various sexually transmitted diseases by 50 percent or more in some studies. Additional studies are underway.

Mr. WAXMAN. We have with condoms the ability to stop the transmission of AIDS and other sexually transmitted diseases anywhere from 90 percent to 98 percent, effectively.

Do we have anything else that is as effective? Do we have a vaccine? Do we have any other suggestion of a way to stop the spread of AIDS, other than abstinence from sex?

Dr. Koop.

Mr. KOOP. No, sir. We have no cure, as you know. We have no vaccine on the horizon. With all the failures and drawbacks, condoms are the only thing we have in the way of a mechanical barrier, although other things, such as spermicides, are now under study, as you know.

Mr. WAXMAN. This is the information that is going to be important to stop the spread of this disease that will take more lives. How can we refrain from not using every source available to us to communicate that message?

Wouldn't advertising be a more effective way of communicating that message? Wouldn't it have a special impact on reaching specialized groups that might not otherwise get the message? Can you comment on that?

Mr. KOOP. Sir, I think it would. Let me tell you one of my great concerns, the rise in AIDS among black and Hispanic people. Blacks account for 12 percent of the population, but they account for 25 percent of the AIDS cases, whereas Hispanics account for 6 percent of the population and they account for 14 percent of the AIDS cases. With that increase that I have mentioned, I think that condom advertising aimed at those minority groups, with visual and verbal messages that would capture their attention, could be considered as very positive public health messages, sir.

I am also concerned that the difficulty of getting specific messages across to the public from the Government has been demonstrated. Previous experience with condoms has been largely in reference to contraception. It appears that many people do not understand how to use condoms to prevent AIDS.

I believe that condom advertising could carry some of these messages appropriate to the prevention of AIDS transmission, such as that which I emphasized in my report, that you should use a condom in sexual intercourse from start to finish.

I really believe, sir, that there are health messages that could be taken to the public with the condom advertising and I have to also say that it would be doing a very big job, not at the public treasury's expense.

Mr. WAXMAN. Some of the networks are going to testify later that a lot of people do not want to hear this message. Some people will also tell us that, if we are talking about American teenagers,

they are already very sophisticated, they know a lot about sex, they know more than most of us ever knew at their age, et cetera.

How do you react to those two positions?

Mr. KOOP. I think youngsters are very sophisticated. I think they are bombarded from all media with messages that exhort sexuality. My feeling about the networks is that it is commendable that they have a voluntary code but condoms are being advertised on television and will be more in the future. I suspect the day will come the networks will see that this is a way that we can spread a good public health message in view of the overwhelming threat of AIDS, which you have so admirably outlined in your opening statement.

Mr. WAXMAN. Do you believe that the American people and teenagers especially, as sophisticated as they may be about sex, know what they need to know about sex and AIDS?

Mr. KOOP. No, sir; they do not. I have tried to stress that in recent months; you cannot educate about AIDS unless you educate about sex.

Mr. WAXMAN. Thank you very much. Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

In your presentation, you didn't make reference to it but I will make a brief statement about what this country has experienced in furnishing condoms to a large segment of our population. You will recall in World War II, that Syphilis was not curable. There were about 20 million U.S. citizens in the military at the time, and they were all given condoms, provided with sex education, and conscientiously inspected after returning from leave for infection.

Notwithstanding that herculean effort, the level of syphilis in this country went up to 400 cases per 100,000, the highest rate ever recorded.

Doesn't that tell us something? Can't we anticipate that same result being applicable to the situation we are now confronting? The inference that we learned from that experience, is that when the Government or private industry seeks to advertise that a certain product, in this instance, condoms, will prevent the spread of a venereal disease, such statement had the opposite effect in 1942 and the years of the Second World War. What makes us believe that we would have a different experience today?

Dr. Koop.

Mr. KOOP. I don't think we have ever said we will have a different experience, sir. I think what the syphillis/condom experience you have recounted does is tell you something about human nature about the time of World War II. What it does not tell you is what the incidence of syphillis would have been if there had been no effort on the part of the Government to give condoms to service men who were exposed to venereal disease. I'm sure it would have been more.

Mr. DANNEMEYER. You mentioned that the use of condoms is an effective tool. Is it the only tool that we can use from the standpoint of Government policy to prevent the transmissibility of this fatal disease?

Mr. KOOP. Government policy, as I have enunciated, does include abstinence. It does include mutually faithful monogamous sexual relationships. Once those are gone, and human beings being what they are, we have to say that if you don't heed those two warnings,

then the next best thing is to protect yourself with a condom. We do indicate that you have to know how to do this and there are failure rates.

Mr. DANNEMEYER. Aren't there other steps that the Federal Government can take in order to reduce the incidence of transmissibility of this disease? Specifically, I am talking about the issue of making it a reportable disease, such as any other communicable disease.

Mr. KOOP. Sir, we have testified—I and others of the Public Health Service—in reference to the problems of mandatory AIDS reporting. AIDS carries a tremendous stigma with it. It has been the experience in certain localities of the country, when reporting has been mandatory, that the very people we are trying to reach with an education program tend to go underground and that is something we would rather not see.

Mr. DANNEMEYER. It is true today that common venereal diseases such as syphillis or gonorrhea are reportable diseases?

Mr. KOOP. That is right, sir.

Mr. DANNEMEYER. Why do we have the whole concept of a reportable disease? What is the policy reason behind making them reportable?

Mr. KOOP. The policy behind the diseases other than AIDS that you mentioned is that when you have a person who has the diagnosis, you can treat him. If you contact those partners with which he or she has been, you can also counsel them and treat them. With AIDS, when you tell somebody who is seropositive that you would like to know who his or her contacts are, the reply is "why?" And you say, "Because we would like to track them down and give them some advice." He or she says, "Treatment, prevention?" You say, "No, but we would like to tell them something about education."

Knowing the stigma that goes with this and the fact that such a patient might be shunned or lose his or her job, you find that those individuals who are seropositive are not very anxious to cooperate in this regard.

Mr. DANNEMEYER. Isn't it true that there are three basic policy reasons why we make diseases reportable? One, to gather statistical information in order to find out the magnitude of the problem we are dealing with. Second, to cure it if we can. Third, to prevent its transmission to others? Aren't those basically the three reasons?

Mr. KOOP. That's right, sir. We are gathering the statistics. We do not have a cure. I have already, I think, covered the third point.

Mr. DANNEMEYER. In your response by saying the sensitivity of the persons with the disease, aren't you really treating this issue as a civil rights issue rather than the public health issue that it really is?

Mr. KOOP. I don't believe so, sir.

Mr. DANNEMEYER. Isn't it sound public policy that we make this a reportable disease. The rationale is basically this; in California today, if a physician encounters syphillis or gonorrhea, common venereal diseases, by law that physician is required to report these cases to the Public Health authorities. There is another law that makes it a crime for a person with a curable communicable venereal disease to have sexual relations.

On the other hand, the virus for AIDS is not reportable. Therefore, if you have a curable communicable venereal disease, it is a crime for you to have sexual relations with another person. A physician is required to report it to the Public Health authorities. If on the other hand, you have a non-curable, communicable, venereal disease such as the virus for AIDS, if the doctor reports it, he commits a crime and there is no proscription at all on the conduct of the person having the virus.

How in the world can you and Public Health authorities justify a paradox of that type?

Mr. KOOP. I think the paradox that you have painted, sir, is due to the fact that the first diseases you mentioned are curable and are preventable. Whereas the disease of AIDS is a very specific one; best public health minds that have gathered in this country repeatedly to talk about this and the method we should follow, have come to the same conclusion that I have just presented: we have more to lose than to gain by following through on mandatory reporting at this time.

Mr. DANNEMEYER. Isn't the defect in that response, sir, that during the time that syphillis has been reportable as a communicable venereal disease, at least initially in the mid-1940's, it was not curable? In other words, we required that a venereal disease such as syphillis be reportable in the 1940's and yet if that is sound public policy at that point, why is it not sound public policy to do the same with respect to those with the virus or AIDS?

Mr. KOOP. I think because of the experience that has been learned in certain parts of the country when this was used. I should have made it clear, if I didn't, sir, that AIDS is reportable in all 50 States; some States do report positive results.

Mr. DANNEMEYER. It is true that those who have AIDS are reportable. I am saying sound public policy demands that those who have the virus also be reported; isn't that correct?

Mr. KOOP. We have not thought so, sir.

Mr. DANNEMEYER. Aren't you at that point treating it as a civil rights issue rather than a public health issue?

Mr. KOOP. I have already said I don't believe so.

Mr. WAXMAN. The gentleman's time has expired. Mr. Bates.

Mr. BATES. Thank you, Mr. Chairman; just a few questions.

I am really more in an exploratory mode in terms of trying to learn more about this problem and I really do not have any preconceived notions on how we should deal with it. It certainly is a baffling and perplexing problem.

One question I had was in addition to condoms, there has been a great deal of discussion of the possible role of spermicides in reducing the transmission of AIDS. I wonder, does the Public Health Service have research on this subject? If you could comment.

Mr. KOOP. Yes, we do, sir. With your permission, we would be very happy to provide you with the protocols of several studies that are going on across the country at the moment, about the effect of spermicides, with and without condoms.

Mr. BATES. I understand that the NIH was funded a $2 million grant in Los Angeles to study the anti-viral effects of spermicides. I wonder if you might just elaborate a little bit on that in terms of how viable this option is and what we know to date on that.

Mr. KOOP. I think I will ask Dr. Noble to answer that. If that isn't satisfactory, we can find some other people in the audience.

Mr. BATES. Thank you.

Mr. NOBLE. The study basically has three phases. The first is to examine the condom and other barrier techniques, including spermicides, for their effectiveness in the laboratory setting of killing the AIDS virus. There is a second phase in which ethicists and scientists will come together to decide how best to do this kind of very difficult study, which involves one of the most sensitive and difficult areas of human behavior. The third phase would be a large clinical trial, to determine the effectiveness of condoms and other barrier techniques, including spermicides, which have been determined in the first phase to be the most ideal candidates for this third study phase.

Mr. BATES. What is the timeframe you anticipate before you complete those three stages?

Mr. NOBLE. Six months for the laboratory phase. A year to a year and a half for the final third phase.

Mr. BATES. This next question, I hope I can phrase it properly. It, to some extent, will be asking for your personal or subjective evaluation, and this is not meant to be terribly critical of the networks, but I'm trying to understand the value of our society and perhaps some of the value judgments that we use to determine the behavior, what goes on the air and what does not go on the air.

For example, we know that even before shows such as Dallas and Dynasty, in a 1-year period of time, there were an estimated 20,000 scenes of suggested intercourse and behavior, sexual comment, innuendo, et cetera, and that's not to delve into the other areas of violence and killing that appears to be acceptable for viewing by the American audience, and yet something that is directly related to a prevention of a sexually transmitted disease is not allowed.

And I'm just wondering what—whether this is your field or not—but what basis do you think we have for making these kinds of judgments, or what would you speculate is the values?

I mean, on the surface, it seems obvious that maybe killing is something we would watch, and advertising condoms is something we wouldn't, given the decisions that have been made. But I sort of want to reject that, and I just wonder how we got ourselves in this position where those are the things that we view.

Mr. KOOP. As I believe I follow your train of thought, you could make a good case that if television networks do, indeed, peddle all the attractive parts of sex, then they should be willing also to peddle something that might prevent the transmission of a sexually acquired disease.

But I think even without that relationship, the threat to the people of this country that Congressman Waxman outlined so well in his opening statement is so great that the public health message and the preventive aspects of AIDS that would accompany condom advertising, speak for themselves.

Mr. BATES. Very good. Just to follow up on that just a little, though, even though some would argue that viewing violence and killing is not a threat to our society, it seems to me that there is a relationship between the viewing of that kind of behavior and perhaps the increase in these kinds of crimes that leads us to lead the

world in terms of violent crimes. And I'm just wondering if maybe I'm getting a little too far afield, but maybe this is something that the Surgeon General should speak out on.

Mr. KOOP. Well, this Surgeon General has spoken out on it for 5 years now, calling attention to violence as a public health problem. We have had a number of workshops and regional meetings on this, and I'd be very happy to send you, sir, the summary of all of those, because I think they support just what you've said.

Mr. BATES. Thank you.

Mr. WAXMAN. Thank you, Mr. Bates.

Mr. Coats.

Mr. COATS. Thank you, Mr. Chairman.

Mr. Chairman, there are a number of Members on the minority side who are not here this morning, and I assume on the majority side, that had some questions for Dr. Koop. I wonder if I could ask unanimous consent that the record be kept open, so that they could be submitted to him in writing, and we could get the replies back?

Mr. WAXMAN. Without objection, the record will be kept open for all members who wish to propound questions, to send them out and get responses in writing, and they will be inserted in the record.

Mr. COATS. I also ask that the witnesses be requested to answer any of the questions that are asked of them and submit them back to us in writing. Is that——

Mr. WAXMAN. Well, Mr. Koop, I'm sure you would be willing, and we will make that request of all witnesses today, that if members wish to submit questions in writing, we will include the responses in the record.

Mr. COATS. Mr. Koop, I know that this is not looked on as perhaps a realistic alternative, but I'm wondering if you can comment. I know you have in the past commented about the moral dilemma that we're facing in terms of perhaps encouraging further sexual activity by just stressing the use of prevention rather than abstinence.

Could you comment on any program that you are aware of? I know there are a number of groups that are attempting to promote abstinence. The Catholic Church has some programs; other groups have a program. I'm aware of another one called "Just Say No" and another one called "Why Wait?"

Are we unrealistic in looking at these as an alternative, or what is your evaluation of all this?

Mr. KOOP. Let me say, sir, that in preparing the Surgeon General's report that the President requested, which was released in October, I met with 26 groups of people in this country who have a stake in education or some phase of the problems associated with AIDS. Every one of those were of the same mind, that the first and only positive way that you can prevent AIDS is abstinence.

But as Mr. Waxman has stated, that's not terribly realistic in our society. After that——

Mr. COATS. Excuse me. I guess what I'm concerned about is that your statement says that the best protection against AIDS infection right now—barring abstinence—is condoms. It's almost as if abstinence is an afterthought, that you've concluded that that's just not a realistic approach, and therefore we have to go to the other.

Mr. KOOP. Not at all, sir. If you will read my report to the American people, you will find that before we talk about condoms, there are 13 moral statements that have to do with abstinence, with mutually faithful monogamous relationships, and with advice to teenagers. The way I stated it, was only for the purposes of being able to present testimony in a short period of time. I could go on at great length about that if you wish.

Mr. COATS. Do you have any confidence that those programs might be effective to some degree?

Mr. KOOP. Yes, I do. And I think that one of the things that's happening in this country is that sex education, which for several decades was very free-wheeling and not with any value system, is changing. And there are a number of sex curricula; some are directed toward Roman Catholics, some toward the Jewish faith, some toward Protestants. But many of them now are hitting all of the things that I think you have in mind, the moral attitudes of young people that would lead them to a different type of lifestyle.

And we have pointed out in the report and in several testimonies since that time, that with AIDS, if you walk down the scientific path toward containment of this epidemic, the moral path parallels that, and not many public health problems can say that.

Mr. COATS. All the emphasis now in terms of the controversy over the advertising on television, the school-based health clinics, and so forth seems to put the emphasis on the dispensing of contraceptive devices, primarily condoms.

Do you have any concern that this emphasis on just this one side of the question might lead to further public acceptance or diminishing of the moral implications and more of an acceptance of sexual activity as long as you take preventive measures?

Mr. KOOP. I think the question you raise, sir, is being studied right now, and in a year or two we'll know whether or not some of these things you've mentioned do have a deleterious effect on moral behavior of young people.

But for everything that you mentioned, school-based clinics and so forth, there are other forces in this country of a more conservative nature that are pushing the things you've mentioned. Just the term "school-based clinic," for example—that's a buzzword which to some people means a place where contraceptives are given, where abortion advice is given. But to others it means a place where there is the kind of prenatal care that a pregnant girl should have for herself and her baby and a place to teach that individual some kinds of parenting. So one has to be very careful in just saying, "School-based clinics lead to this," because there is more than one kind of school-based clinic, as there are of all these programs that you've mentioned.

Mr. COATS. Is it realistic to think that those sophisticated enough—maybe sophisticated is the wrong word—those engaged in sexual activity, particularly those high-risk groups that are more prone to receiving the AIDS virus, are not aware that condoms are a preventive measure?

In other words, how effective is, say, TV advertising or magazine advertising or a big push here on the use of condoms? Are we being unrealistic in thinking that this is going to make a dent in this problem?

Mr. KOOP. I don't know whether we're being unrealistic or not, because we haven't tested it. There is no doubt about the fact that young people consider themselves to be immortal. When you talk about risks to themselves, they always think it applies to the other young people but not to themselves. And I think we'll just have to see over the course of several years whether or not this type of education is credible.

Remember, another problem in this country with which I've been deeply associated, and that is smoking. It took 25 years to reduce smoking in this country from 52 percent to 29 percent. I think most of it came from a constant hammering away at the health effects of smoking, and I think that has something to offer itself here.

And we are, as you know, on the verge of releasing to the public our Public Health Service report on a huge educational effort and an evaluation of each of these steps as part of that program.

Mr. COATS. Do you have reservations about the fact that, maybe not initially; but at some point, the pharmaceutical companies and the advertisers will subtly move from selling condoms as a health preventive measure to selling sex or selling condoms in a war of competition to see who's going to increase their marketshare and subtly encourage sexual activity as a way of increasing that bottom line? Is that a reservation you have?

Mr. KOOP. It isn't a reservation I have, although it is a risk that I see. And I might tell you that it is my intent to sit down with the major manufacturers of condoms and discuss just some of those things to see if we couldn't have some kind of a concerted effort, so that that doesn't happen in the future.

Mr. WAXMAN. Thank you very much, Mr. Coats.

Dr. Koop, we appreciate your testimony today, and more than that, your leadership in this effort and in other public health measures as well.

Mr. KOOP. Could I add one word?

Mr. WAXMAN. Certainly.

Mr. KOOP. To Mr. Dannemeyer. I should have said that the Public Health Service will be having a conference on the very issues he raised about reportability of seropositivity and stress once again that AIDS is a disease like none other that we have ever encountered. And that is why the Centers for Disease Control will be spending 2 days this month with people from all over the world to discuss the advisability of some of the things that Mr. Dannemeyer has raised.

Mr. WAXMAN. Thank you very much.

Mr. Dannemeyer.

Mr. DANNEMEYER. Will we have an opportunity of a second round with Dr. Koop?

Mr. WAXMAN. If you desire a second round, this is the time to claim it. Do you wish to ask another round of questions?

Mr. DANNEMEYER. I would like to do that.

Mr. WAXMAN. The gentleman is recognized for 5 minutes.

Mr. DANNEMEYER. Thank you.

Dr. Koop, the evidence indicates that in 1960 we had a 15 percent rate of teen births out of wedlock. As a result of the enlightened age in which we now live—$145 million now spent annually for family planning, rate of teen birth in 1984 was 56 percent. We

in America, by spending this tremendous sum of money to tell the people of America how to prevent pregnancy, have now reached the point where we have the highest teen pregnancy rate in the Western World. The U.S. rate is per 1,000 while our closest competitor, is France, has only 90 per 1,000.

Doesn't that seem to say something to us? We should take these statistics into consideration before we go down the same road again—namely, the World War II experience I alluded to earlier? The U.S. has the highest rate of teen pregnancy despite the tremendous sum of federal dollars spent on family planning?

Aren't we really failing to see what experience has produced in previous cases—namely, if we go down the road today of extensively involving the Federal Government in fostering the use of condoms to prevent AIDS, we're going to have just the opposite result?

Mr. KOOP. I don't believe that this is going to have the opposite result, sir, and I decry the rate of teenage pregnancy in this country, I think probably as much as you do, and I recognize that all educational programs that try to change lifestyles, especially when it's something as enticing as sex, are doomed to perhaps initial failure.

But again, I think public health experience indicates that, if at first you don't succeed with an educational program, you keep trying. And although this may be a grim message, I think that it will begin to have more and more acceptability with young people as they see more and more people that they know personally dying from behavior which leads to AIDS.

Mr. DANNEMEYER. A survey from the Office of Family Planning conducted by Dr. Grady of Battelle Research Institute, released September 1986, found that there is a condom failure rate of 18.4 percent for persons under 18.

How does that compare with your 10 percent rate?

Mr. KOOP. You can get all kinds of bias in reference to cohorts that you study; in my testimony, Mr. Dannemeyer, you will recall I said I don't think that most people know how to use a condom for the prevention of disease, because most of them have their experience with condoms for contraception, and they are entirely different.

If for contraceptive purposes you have intercourse and then put on a condom, that is perfectly satisfactory to prevent pregnancy; but that would be totally unacceptable behavior to prevent the passage of sexually transmitted disease. And that's why I said that even advertising might be very helpful in getting this message across to young people or old people, anybody who is sexually active and at risk: you have to use a condom from start to finish, if it is to be any kind of a protective mechanism against the spread of a sexually transmitted disease.

Mr. DANNEMEYER. A study published on Friday, February 4, 1987 estimates that the condom failure rate is approximately 1 out of 10. By the time of printing, that figure had risen to 3 out of 10. The study involved 24 couples. Of the 14 who didn't use condoms, 12 sero converted over a 1- to 3-year period. Of the 10 who did use condoms, 3 out of 10 sero converted.

If we double this 3-year period to 6 years, what would be the probable result, Dr. Koop?

Mr. KOOP. I'm not enough of a mathematician to tell you, but I would say that——

Mr. DANNEMEYER. Well, it takes—my question relates to the latency period that is involved with AIDS. As you know, sometimes it takes as much as 5 years before those with the virus manifest symptoms.

Mr. KOOP. Well, that's not the issue you're raising. You're raising seropositivity, and we should not be confused with what is going to happen to those seropositive people in the future.

But certainly 3 out of 10 is a lot better than 12 out of 14.

Mr. DANNEMEYER. Isn't the another step that would make sense from the public policy standpoint? For instance, in California, we've had a law on the books since 1957 which says that any person with a venereal disease who has sexual relations with another person commits a crime. The rationale behind that law is that it is in the public interest to prevent the transmissibility of a communicable disease. And bear in mind, that's a curable communicable disease.

Isn't it sound public policy, and shouldn't you be recommending to the people of this country today that we have a law on the books that says, "If you have a non-curable communicable venereal disease, such as the virus for AIDS, if you transfer bodily fluids to another person, you commit a crime?" Isn't that sound public policy?

Mr. KOOP. Well, that's a California law, sir, and I am a Federal health officer. I really don't have the ability to make that kind of a proposition into law.

I have already said that AIDS is an entirely different disease than any other. AIDS kills, and sexually active people have to be told this. The CDC is reinvestigating whether any of the things you have suggested this morning might at this time be applicable to public health policy; I would be very foolish to try to give you what an opinion of this group of experts will tell us in less than 2 weeks time.

Mr. WAXMAN. Thank you, Mr. Dannemeyer.

Mr. Tauke, do you have any questions?

Mr. TAUKE. I think it would be inappropriate for me, having just arrived. I will wait for the next round. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Dr. Koop, we thank you very much for your presentation, and we look forward to working with you.

Our second witness is Dr. June E. Osborn. Dr. Osborn is a member of the National Academy of Science's Committee on a National Strategy for AIDS. That committee published its special study and recommendations on AIDS late last year.

Dr. Osborn also serves as Dean of the School of Public Health at the University of Michigan. She is among the nation's most respected experts on the AIDS epidemic.

Dr. Osborn, thank you for being with us today. We have your prepared statement, and we will make that part of the record in full.

What we'd like to ask you to do is summarize that statement in no more than 5 minutes and then we will have some questions for you.

STATEMENT OF JUNE E. OSBORN, DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

Ms. OSBORN. Thank you, Congressman Waxman and members of Congress. I am pleased to have the opportunity to speak to you today. I don't believe my statement will take longer than 5 minutes to read it, and I will read it and be pleased to answer questions and make additional comments.

I am delighted to have an opportunity to talk about preventive measures which can be deployed to impede the further spread of the virus of AIDS. My message can be put quite simply.

We have a few undramatic but very effective weapons with which to combat further extension of the AIDS epidemic and time is of the essence, for the actions that we do or do not take now will have their impact years hence and may make the difference between manageability and overwhelming trouble in the future course of the epidemic.

Condom usage during sexual activity is one of the very few effective means currently available to prevent viral transmission. Since the disease we are trying to prevent is deadly and likely to remain incurable for a long time to come, I believe that all reasonable measures should be deployed to make that information available. Among the few interventions we have, the encouragement of condom usage stands out as a realistic strategy of great importance and we should be using all available media and avenues of communication to convey that important fact to the public.

It is my hope in these few moments to provide a partial antidote for the anesthetic effect that public health presentations sometimes have on busy people. Numbers often do numb us. The AIDS epidemic is introducing havoc into the personal lives, not only of sexually active or drug using young adults, but of their families, coworkers and friends. It threatens a whole new generation of adolescents, among them possibly your children and mine, and soon no one in our society will be untouched by the pathos associated with this dreadful disease.

In fact, the impact of AIDS even now makes the era of herpes' anxiety look like the good old days. Matters will get at least 10 times worse in the next 5 years, even if we do everything right and bring further spread of the virus under control immediately.

The handwriting on the wall for the next 5 years is truly appalling. I think we will be hard pressed to cope with the numbers of persons already infected and with the problems that stand in the way of providing them with compassionate cost effective care.

What we do now will spell the difference beyond that. We have learned a great deal about the new virus and its limited modes of transmission. Now that we have that knowledge at hand, we have an urgent duty to warn and we must use every available societal avenue to broadcast our preventive message.

The virus of AIDS is not easily transmitted, only sex, blood and birth have proved effective as modes of transmission.

This country responded with dazzling speed to the threat to the blood supply. I am very proud and admiring of the dedicated scientists and Public Health officials in the U.S. Public Health Service, who wreaked a small miracle in the efficient and effective way in

which they worked together with many concerned communities to mobilize and meet that threat.

The response spared no expense. Indeed, the development of the blood test for virus antibodies and its deployment has added several dollars to the cost of each unit of blood now used in this country. That added cost was deemed appropriate to prevent the deadly disease, AIDS.

We must approach sexual and drug use related transmission of the virus with the same determination. Data are accumulating rapidly to strengthen the assertion that condom usage is highly effective in blocking transmission of the virus of AIDS. The condom is a mechanical barrier, of course, and therefore, its integrity can be breached. It therefore cannot be viewed as a panacea or guarantee of safety. Most of us would advocate even more powerful protections; limitations of numbers of sexual partners; full knowledge of the history of one's sexual partners; monogamous lifestyles and abstinence, where one's personal lifestyle makes that an acceptable alternative.

I personally would urge a loved one or friend to enhance his or her chances of safety by those additional strategies.

Human history tells us that large numbers of people in most societies, and certainly in ours, have chosen non-monogamous lifestyles, that relatively anonymous or brief sexual encounters occur with some frequency, and that homosexuality is a prevalent sexual orientation and that bisexuality is a frequent or occasional fact of life for more men than we commonly acknowledge.

Furthermore, adolescent experimentation is almost a redundancy of terms, and while we all have survived adolescence, most of us can probably remember stupidity as we would rather forget. The penalty for a false start should not be a fate worse than death.

Those of us near the eye of this storm sometimes feel like shouting out loud to attract more attention. Jim Curran of CDC has predicted that by 1990, people will be shaking their fists at us and saying, why didn't you tell us. Of course, there will be no satisfaction in saying, we tried; if in fact we don't succeed.

AIDS is a deadly affliction, a cruel fate from which no one has returned to full health and almost all progressed to dreadful death. The virus of AIDS is a sneaky one, a pathogen with an incubation interval so long that the most conscientious of infected carriers might inflict unthinkable woes on beloved sexual partners if not properly warned.

I believe that the few things we can do between now and the time years hence, when technology comes to the rescue, as it were, are in fact all we need to do for containment of the epidemic, if we do them convincingly. We do know about sexual spread. We do know about the efficacy of condoms in curtailing that spread. We must say so with all means at our disposal.

Thank you.

Mr. WAXMAN. Thank you very much, Dr. Osborn.

Let me just ask you the question as clearly and simply as I might. Do you support the advertisement of condoms on television?

Ms. OSBORN. Yes. I think it is one of the means available and I think therefore, it should be deployed, as I said.

Mr. WAXMAN. Do you think it is irresponsible given the magnitude of the AIDS epidemic, not to have the most effective media giving information out to the public—television—refrain from allowing advertising of a product that can stop the spread of AIDS?

Ms. OSBORN. I am not very expert at the media's decision making processes, but I would love to see the media get into the public education campaign that I think is urgently needed immediately and in fact, sooner than that.

Mr. WAXMAN. Some members have expressed the concern that one of the messages we ought to be sending out to young people particularly, is that they ought to abstain from sexual actions, sexual relations, until marriage. They also say people who are married ought to continue in a monogamous relationship. These, I think, are consistent with our values that we all share. These messages should be sent out to the American people.

But how effective—from a public health point of view—would that message alone be in stopping the spread of this disease?

Ms. OSBORN. I suppose from a public health point of view, I can't comment, but from an amateur historian's point of view, I could comment that it would be very ineffectual. I, in fact, think that perhaps the message about utilizing condoms, envisioning sexual encounters, particularly brief ones, as a hazardous activity, may well lend more momentum to that desire for a relatively monogamous society than many of the tactics we have taken in the past.

I don't see the activities as inconsistent. I certainly think that the duty to warn is extremely strong, as I mentioned in my statement. Adolescent experimentation is not always trivial, as we know from many contexts, drugs and so forth, but it shouldn't be deadly. We should be able to warn our youngsters that when they ultimately settle to a lifestyle that we hope will be close to that which you described, that they will not have flawed themselves fatally in the process of arriving at that decision.

Mr. WAXMAN. A number of other countries, including Great Britain and Switzerland, have undertaken massive public education campaigns about AIDS and about condom use. The National Academy of Sciences' report, that you participated in, also recommended such action.

Why do you think that the United States, with the largest number of AIDS cases of any industrialized nation, has been so slow to educate the public? Do you think a campaign should be begun now on a massive scale?

Ms. OSBORN. The answer to the last question is absolutely. I think we are very late. I am very admiring and envious of the countries that you mentioned for having reacted much more quickly. My understanding is that the United Kingdom began their public campaign with less than 500 cases. We have over 30,000 cases, that has been brought out, not to mention that simply representing today's problem with many, many more infected individuals.

I think a public campaign should be launched as quickly as possible. I believe the U.S. Public Service, Centers for Disease Control, are very quickly mounting one.

Why we are late, I don't know. We have been saying this for some long time now. I think it is very difficult to talk about sex in

the news hour in society. It is really not difficult to talk about it in the soaps. I don't understand why that is.

Mr. WAXMAN. Your explanation for why this country with so many more AIDS cases than England, Switzerland or even Italy, has taken so long to get to a point of discussing this question, is because of our ambiguity about sex, our uneasiness in talking about it, our cultural fears about sex? Is that what is holding us up?

Ms. OSBORN. That's part of it. I think in all fairness to the people who have been working very hard, we also have the unpleasant role of being the forerunner in this epidemic. Therefore, we have learned lessons from which other countries are benefitting. My whole hope would be that we can now stop doing that. We have a very well established epidemic and the information is there from which the lessons can be drawn. Now it is time to stop seeing that lag behind us, as other wise societies learned from our problems.

Mr. WAXMAN. Other than actual increased sales and use of condoms, do you believe that advertisement of condoms will have other beneficial public health effects?

Ms. OSBORN. I think the things that have been said here this morning about the prevention and transmission of sexual diseases should not be minimized while syphilis and gonorrhea are curable, herpes is not. There are a number of possible additional benefits in the use of condoms as prevention of sexually transmitted diseases that would have major public health effects.

Mr. WAXMAN. Thank you very much. Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

I noticed that you teach in the Department of Public Health, University of Michigan.

Ms. OSBORN. School of Public Health. I teach in the Department of Epidemiology.

Mr. DANNEMEYER. You are the dean there?

Ms. OSBORN. Yes.

Mr. DANNEMEYER. How long have you been the dean?

Ms. OSBORN. I have been dean of the School of Public Health since July 1984.

Mr. DANNEMEYER. Have you spent your career in the area of teaching in the School of Public Health?

Ms. OSBORN. No, sir. Before that, I was a member of the Medical School faculty at the University of Wisconsin for 18 years. I am a virologist, a viral immunologist and a pediatrician.

Mr. DANNEMEYER. You have quite a background. It is nice to have you here.

Ms. OSBORN. Thank you.

Mr. DANNEMEYER. When you consider the fact that in 1973, the American Psychiatric Association changed its evaluation of homosexual conduct from abnormal to normal and then about the mid-1970's, many States in the Union eliminated the laws proscribing sodomy. Those two acts and others that I can mention really said to the American people, if it feels good, do it, there are no limits or restraints on human conduct. There are no fixed standards on life in America any more. Go at it.

We have really fostered a sexual revolution; wouldn't you say that is correct in America?

Ms. OSBORN. I wouldn't know what to say about that, sir. I'm a pediatrician. I see each generation of children growing up with a set of challenges and threats to their success at becoming useful and happy adults, whether or not somebody has fostered trends in society or whether they happen by virtue of outside forces, I am not expert to say.

Mr. DANNEMEYER. Do you believe we can separate in the field of education, sex education from morality and ethics and conscience?

Ms. OSBORN. I don't think we can separate education at all from morality and ethics and conduct. I think the preservation of human life and health is my strongest ethic and this is very important now, to be able to bring that forth as a very important component in this discussion.

Mr. DANNEMEYER. Within the scope of our hearing today is private advertising, advertising condoms. When private advertisers do that, they have certain strictures that pertain to their activities. When the Government gets involved in it—let me ask the question this way; do you believe the United States Government should be involved in condom advertising?

Ms. OSBORN. I doubt that they need to be involved, sir. I don't know enough about the law behind it. I think the United States Government should be in the position of advocating condom usage as a means of limiting the spread of the virus of AIDS by whatever means it deems appropriate. Again, I have to back off because I don't know——

Mr. DANNEMEYER. Don't we have somewhat of a dilemma then in our society? You believe the Government should be involved in advocating the use of condoms for preventing the spread of AIDS, and the moment that we add the element of conscience and ethics and morality to sex education, there will be those in our society who will say we have crossed the line and therefore, any effort on the part of the Government to combine morality and ethics and conscience with respect to education in sex would be a violation of the First Amendment of the Federal Constitution?

Ms. OSBORN. I think perhaps our problem is with the word "advocacy." My feeling is that the Government and the U.S. Public Health Service have a very strong role to play in the context of what I think of as the duty to warn. We have a very large body of information with which we can educate the public, including the fact that condoms are essentially the only effective thing that we have to turn to beyond the advocacy or the advisement that abstinence and so forth are available as the best and safest alternatives in the context of this epidemic.

That information must be broadcast, in my view. The role of the Government, the role of media, the role of private and community organizations, is something that we will all need to work out. We cannot afford to get into small arguments with a huge problem. I see the duty to educate and to advise as a very important one that the Government can be helpful with. Perhaps that is a better way of putting it.

Mr. DANNEMEYER. In the report that you helped write in confronting AIDS, your group stated on page 11, "An educational campaign must be willing to use whatever vernacular is required to get the message across."

Could you tell us specifically what you would recommend be shown on television?

Ms. OSBORN. I don't believe that anything rules need to be broken with what is already shown on television, to get across the message that I am talking about. I think what needs to be said is that condoms can be an useful adjunct in the prevention of AIDS, if one's sexual partner is infected. There may well be some additional information that can be conveyed with that. I think Dr. Koop has told you that the U.S. Public Health Service is studying that with some intensity to see what will be an effective message and what kinds of communications can be achieved that way.

I'm glad you picked on the comment in the report about the vernacular, because I think we have to be clear. If we want to get across a message to someone, we have to speak in that someone's language, not in some very arcane language that is particular to those of us who have been fortunate enough to be highly educated. We have a society with a rather substantial, in fact, an embarrassing illiteracy rate. The television media in particular becomes very important in that context, to get across messages. They need not be purism in order to be effective.

Mr. WAXMAN. Thank you, Mr. Dannemeyer. Mr. Bates.

Mr. BATES. Thank you, Mr. Chairman. I first just want to state that I am coming to the conclusion that moral values and sexual education are not mutually inconsistent. I think we can have both and I was particularly taken by your phrase, small arguments on huge problems. This is certainly a huge problem.

Another aspect of this problem that occurs to me while we have been debating the moral aspects of sexual behavior, that there may be a false sense of security that science will save us or that a vaccine will be developed shortly and whatever is wrong, we will find a cure.

I notice that you are a member of a committee on a national strategy for AIDS. I would be curious and I know this will be purely conjecture to some extent or speculative on your part, but can you discuss at all the time frame that we are looking at in terms of a possible vaccine in say the earliest and the latest dates that we are looking at so that in the interim, there obviously has to be a strategy and I think education is the strongest option at this point.

I would be interested in your views on that.

Ms. OSBORN. I would be pleased to comment. First of all, let me point out that a vaccine is to prevention like condoms are to prevention.

Avoidance of the virus is a far more effective strategy than a vaccine ever hope to be were it available tomorrow. So that we still do have a very major problem if we were to have a vaccine in hand.

Insofar as it is not particularly speculative, the National Academy of Sciences Institute of Medicine committee spent quite a while discussing vaccine possibilities and strategies and I also serve on some NIH advisory committees in that regard and I am a virologist, so perhaps I can speak more strongly.

At the moment, there are a variety of early steps, toes in the water, if you will, toward a vaccine strategy but they are all shad-

owed by the fact that this is a very different virus infection from the kind for which we have vaccines.

It is chronic. It becomes latent and it has very little evidence that antibody in the usual sense that vaccines invoke them has a lot to do with even protection of the naturally infected person, so there are some strategic problems with this virus infection that have not pertained in earlier assaults on major epidemic viral problems.

I think any virologist you will talk to will say that that is going to slow things down somewhat. The very best minds are working very quickly and there are a variety of candidates designed to circumvent those problems.

But let us suppose, for instance, that we had such a candidate. You would have a terribly difficult time establishing meaningful control groups and experimental groups. We might not even be able to afford the luxury of a control group with the cost benefit analysis in ethical terms that sometimes are discussed here.

But let's suppose that we could pass that problem. We are talking about preventing a disease with a 4-year incubation period. We would have no way of being sure that we had not done more harm than good until several years into a vaccine trial.

It is not unthinkable that a false start in a vaccine direction could, in fact, create some problems of its own in perturbing the immune response of people who subsequently became infected.

There are many complicated issues involved in this but even clearing the way from those complexities, with a disease with a 4-year incubation period, we are very far away from being able to say that we have an effective vaccine.

We are at least 4 years away plus whatever time it takes to do the basic science and then to go through phase one studies and get into phase two studies.

So there is a very long road, one we must travel. I don't mean to minimize the potential usefulness of a vaccine and, in fact, if the epidemic continues its path the way it has been behaving in other parts of the world, it will become urgently important that one be available.

But we are a lucky society. Our science has told us what we need to know to prevent the further spread of the virus today and to wait for a vaccine would be close to criminal.

Mr. BATES. I was more hopeful until you spoke. I am almost sorry I asked that question. So you are saying at least 6 to 10 years.

Ms. OSBORN. Let me quote the study.

Mr. BATES. I am trying to get an answer that maybe is not there.

Ms. OSBORN. The answer is specifically there in the National Academy of Sciences Institute of Medicine report. It says that it will be 5 years, maybe 10 years, maybe never and that is the consensus of 26 members of the committee.

Mr. BATES. Five years, 10 years, or never. Thank you very much.

Mr. WAXMAN. Thank you, Mr. Bates. Mr. Coats.

Mr. COATS. Dr. Osborn, let's put moral implications and questions aside for a minute and pretend that you are a teacher in a classroom of 13 to 15 year olds or whatever age you want to select and you are giving them a purely clinical discussion, leading them

through a discussion on the problem of AIDS. You have described to them what AIDS is and how it is transmitted and so forth.

Now you are saying, this is the most important part of the classroom. Here is how you can prevent AIDS from happening or these are the steps you should take. What is the most important thing? What is number one?

Ms. OSBORN. Think carefully about your sexual activity. Know your sexual partner. Make some decisions about your lifestyle rather than being swept into behaviors that you may not think are an appropriate part of your lifestyle later and if you are still on your way to sexual activity, know your sexual partner exceptionally well, and most of us cannot fulfill that, I might add.

I think Dr. Koop was the one who commented or somebody fairly recently commented that now that the AIDS virus has been around for a while, if you have intercourse with somebody you may be having intercourse with a lot of other people that they had intercourse with over a long period of time.

So that know your sexual partner business may not be a particularly effective warning. Then if you continue to pursue your decision to go ahead with that sexual encounter, use condoms. Use them properly and appropriately for the prevention of the transmission of the AIDS virus.

Those are the messages that I think are appropriate to a classroom. The how to and so forth is a matter of school jurisdiction which I am not expert enough to comment on.

I might add at the risk of sounding like an advertisement, the Disney Company and a number of other companies have made films designed to do exactly what you are asking about. I had the privilege of participating as a volunteer in the Disney one so I know about it.

I think what needs doing in the public context of the classroom is to set a stage for people to find out what they need to know further by other means. I don't think that one needs to get down to diagram drawings in order to be able to alert somebody to a hazard if that is part of your question.

Mr. COATS. I am concerned that the message, know your sexual partner, think it through, know the sexual history of your sexual partner isn't going to give the message that a clinical psychologist or someone in the public health service ought to be giving.

If this disease is as deadly as you have testified and Dr. Koop has testified and others have said, why wouldn't you tell a 13-year-old, don't have sex. That is the absolute number one thing you must do to prevent death because you can never know for sure. Know the sexual history of your partner, what if they lie to you? What if they don't tell you the truth? Use condoms, 90-percent of them work, but 10 percent of them don't.

Are you willing to risk death to trust what someone, a 14-year-old is going to tell you about their sexual history or what a condom manufacturer is going to tell you about the degree of effectiveness of their condom.

Isn't the first thing you would tell them, "Look, don't have sex and let's discuss why you shouldn't have sex and all the risks and so forth." It seems to me that that would be number one.

I am not saying that is the only message. I agree with you and I agree with Dr. Koop that we have to face reality here that you can give that message to people and not all of them are going to accept it but some are and for those that do at that age, isn't that the best message we can give them and then move on to number two and then move on to number three and then move on to number four.

But you put them all together in number one and I am afraid a 13-year-old is going to be very confused about "Gee, know the history. Oh, well, he said it is okay."

Ms. OSBORN. Perhaps the thing that I did not say clearly at the beginning, if there is one thing I have been doing all of my professional career it is teaching young adults and adolescents and I have three adolescents of my own.

It is my experience and strong belief that if I intend a message like, "Don't have sex" probably the most thwarting thing I can do to certain age groups is to come straight on with it.

What I just did was to tell you a message that most people at the age of 13 or 14 would interpret as meaning exactly what you said. "Don't have sex. It is dangerous." It would be coupled with a message about AIDS which says, "It kills" and that none of the rest of these things I am telling you are sure.

That is, in fact, the way many adolescents and young adults hear the message when I have had the privilege of speaking with them. So I think we are getting at the same message. It is simply a strategic problem and I don't think either you or I, unfortunately, know quite the right way to get through to adolescents.

What I am saying is that we are not even trying right now and we have got to start working at it harder. It is a whole generation that we can lose out of a failure to warn. They won't have the opportunity to add the AIDS reason to their other reasons for pulling back from experimentation if we don't tell them and we have to tell them fast.

Mr. COATS. I don't disagree with you and I certainly don't have all the answers as to getting messages through to adolescents either. What I am concerned about is that we are going to move simply to a message that says, "Hey, everybody has sex. We all know that. Just make sure you use condoms and then there will be no problems."

You said people are going to be shaking their fists at us in the 1990's saying, "Why didn't you tell us?" Might not they also be shaking their fists at us and say, "Hey, you said all we had to do was use condoms and I got AIDS" or 10 percent of these people ended up having AIDS anyway or "I wouldn't have gotten into sex but everybody seemed to think that it was okay and it was the thing to do and the kids were picking them up at school and gosh, you weren't really with it if you didn't stop by the clinic and get your condoms every morning and then you couldn't just carry them around, you had to prove that you used them."

I am concerned that we are not getting the first message out there strong enough and that is, "Hey, if you really are concerned about AIDS, if it is as deadly as it is, maybe you ought to consider waiting until marriage, maybe you ought to consider monogamy as a lifestyle because here are the risks."

I am not talking from a morale standpoint now. I am talking from a purely health standpoint. The moral questions are other questions that have to be addressed and who addresses them is a question we all have to decide on but just from a pure health standpoint, isn't that the best message we can give young people.

Mr. WAXMAN. The gentleman's time has expired. Could you answer briefly and then we are going to have to move on to other members.

Ms. OSBORN. I think that working together that message coming from people most qualified to give it and the kind of graded message of relative safety that we are all trying to give about condoms together can add to a desirable goal that we share.

I don't think that I should spend a large fraction of your time saying what I think morally because that is not why you asked me here to testify.

Mr. COATS. I did not ask you to testify on the moral question.

Ms. OSBORN. I have focused therefore on the relative safety that can be gained by this particular strategy but I think we are not in much disagreement.

Mr. WAXMAN. Thank you, Mr. Coats. Mr. Tauke.

Mr. TAUKE. Thank you, Mr. Chairman. Dr. Osborn, you are a very impressive witness and I thank you for joining us this morning.

What triggers this hearing, of course, is the onset of advertising on television for condoms. I think that both you and Dr. Koop have stressed the need for public education. I certainly understand the need for public education but I want to shift for a moment to a different phase of that public education, specifically, who gives it?

Is it wise in your judgment for us to rely on the ads produced by condom manufacturers and time purchased by condom manufacturers for this public education about the use of condoms and the way in which they may prevent the spread of AIDS?

Ms. OSBORN. If we relied solely on it, I think it would be a very poor strategy and I hope to see a variety of other strategies mobilized instantly or as close to instantly as can be as I mentioned before.

I think Dr. Koop mentioned that he will be in conversation with the pertinent manufacturers as in other contexts where health related materials are advertised. It is my understanding that there is a considerable degree of control over the accuracy and validity of the message that is put forward.

I doubt that we will hear any claims of absolute efficacy, for instance, because the data don't support those and it is my understanding that there will be some considerable interaction in the arrival at a satisfactory text for such promotions.

Mr. TAUKE. It occurs to me that the problem that arises with manufacturer-supported advertising is that inevitably those who are purchasing this advertising time are doing it in order to increase the use of their product.

I don't think they are doing it because they are such wonderful folks who want to educate the public. They are doing it because of the bottom line. They want to increase their profits. Now how do you increase your market share?

Well, you say that this product is going to perform better, it is going to provide greater stimulation or whatever and enhance the product and make it seem more desirable. That is where I see the problem. I don't see anybody in that kind of advertisement saying, "Condoms don't always work in the spreading of AIDS."

I don't see them saying that there are some other ways that are more effective or that there are some difficulties that arise. It seems to me that we are going to get a very distorted perspective of the message that we are trying to send if we rely on manufacturer paid advertising or even permit that to be a significant part of this effort to send a message.

Wouldn't it be better for public health agencies to buy time on television if we can't get it free and talk about the AIDS problem and educate people about ways to prevent the spread of AIDS?

Ms. OSBORN. I think that would be wonderful. I am looking forward to the say when it happens. I find it very distressing regularly to view advertisements for people to be able to join the military in the context of what I perceive as one of the major threats to the U.S. health in not only my memory but in many other people's memories as well.

To see no word of public health warning bothers me badly so I am delighted that you brought it up and I think it is an extremely important additional thing. In fact, its absence alongside the presence of condom advertising certainly would be a strange message and I agree with that point you make but I think we have to do everything and we know that the visual media has a special role in educating and a particularly special role in educating that section of our population who have not had the opportunity to become highly literate and be able to read the warnings and read the pamphlets that people are sending out.

So I think frankly that both of those things are highly desirable. We have to talk about this a lot now and we have to use absolutely every legal means and every legitimate means we have.

Certainly the media have advertised some other things that were rather threatening to public health in the past. I think they can certainly advertise some things that are helpful.

Mr. COATS. I am not opposed to sending the message and I think we ought to send the message very bluntly and straight forwardly. What I am concerned about is who is sending the message and what the motivation is behind the message that is sent and it seems to me that that is a very critical issue.

Let me ask you another question jumping off of advertising. What perspective do you take on the issue of mandatory testing for AIDS?

Ms. OSBORN. I take the same position that the entire committee of the National Academy of Sciences and Institute of Medicine took which is that it is a counter productive idea at this point in time, that we have benefited with those small successes we have had in limiting the epidemic to date by a great deal of voluntary cooperation and indeed forthcoming innovation on the part of some of the involved communities who have been caught up in the epidemic for a number of years now.

I think on an individual basis the fact that we have such a good grasp of where we stand epidemiologically to the extent that we do

has a lot to do with the fact that we have preserved confidentiality and indeed anonymity in testing contexts.

I think we should expand that opportunity so that people who are concerned about perhaps having come across the path of the virus in the past are in a position to reassure themselves or to find out where they stand.

So I think alternative testing sites in the context of very strong confidentiality and where necessary anonymity is an outstanding measure and another one that can help us in the ultimate containment of this epidemic.

However, mandatory is a different matter. I know of no mandatory health activities that work very well and indeed the syphilis example that has been brought up several times is a rather good example in which mandatory doesn't work very well.

The cost effectiveness analysis of pre-marital screening for syphilis, for instance, is very discouraging. That has not been a very useful public health maneuver. Certainly cost effectiveness would argue against some of the very broad strategies for mandatory screening that we have at the moment and instead, in favor of an extension of the available alternative test site opportunities that people have on a voluntary basis.

But I cannot stress too strongly the importance of the confidentiality or anonymity associated with that and I think that to the extent that the question was asked earlier, did I think that was a public health or a civil liberties issue, I think it is both.

I think this country is dedicated to public health in the context of civil liberties. If we ever get undedicated that way, then life will get a whole lot easier for us public health people but a whole lot more difficult for the society. So I think we have to keep working for strategies that achieve public goals within the very clear context of civil liberties.

Mr. WAXMAN. The gentleman's time has expired. Mr. Sikorski.

Mr. SIKORSKI. Thank you, Mr. Chairman.

Thank you, Dr. Osborn. I have just a couple of quick questions.

The recent IOM/NAS report comes up with a host of public health and public education strategies. In looking at the advertising issue, the authors note that the cost of advertising is extensive compared to the resources available in the public sector for that kind of strategy.

I appreciate that, but that's not the only option. As I understand it, the option also exists for advertisers of products to pay for their advertising, and that discussion has already taken place.

Second, we could have public service announcements, which would be a free option.

Is there a reason the authors didn't focus on those options in the report?

Ms. OSBORN. Only space. We talked about that extensively. It's my amateur understanding that there actually is some proscription against the U.S. Public Health Service acquiring prime time on television, which I find thoroughly shocking, and if that is accurate, I hope the committee would look at that too, because I do think that the combined effort is the thing that we're going to have to focus on.

To the extent that we can borrow time through the expense of a given industry, health-related industry, I think that's wonderful, because we're going to have all we can do to make do with a world class epidemic with the resources that can be sprung loose.

So everything is going to help in the longer haul. I think it will help achieve our specific objectives of containing the AIDS epidemic. I frankly think it will help to achieve some of the other objectives that some of the Congressmen have been acting about, too, in terms of an alteration toward a more conservative sexual lifestyle in the longer run.

But for the moment, I'd be delighted to see any moves towards the use of prime time, public service announcements, and all of that sort of strategy. We need it desperately, and, in fact, it's rather embarrassing that we're not doing it.

Mr. SIKORSKI. Especially in relationship to the cost of AIDS' spread and the risk to life and everything else.

Do you agree with the estimate that's been used that the efficacy rate of condoms is only 90 percent?

Ms. OSBORN. Well, that, of course, as I think Dr. Koop mentioned, is an extrapolation from their use as a contraceptive. And if one indeed teaches people to use condoms as a preventive of sexually-transmitted diseases, they have a higher prevention potential than that, from the relatively minimal data that we have available, as Dr. Noble said, that there are some studies ongoing that will add to our information.

But I think that 90 percent is a very conservative estimate in that sense, that it's quite possible that if we do our job really well and educate for their use as preventives of sexually-transmitted diseases, including AIDS, that they could conceivably be more effective than that.

Similarly, I think the developing data about spermicides suggest that the adjunctive use of—perhaps it's unwise to call them spermicides, because I think it's the chemical that happens to have a spermicidal effect also seems to have a potential antiviral effect, Nonoxynol-9, than some of the other spermicidal chemicals—but that adjunctive use may even increase those odds.

It's important to make a big distinction, I think, between the prevention here in which you have a—one mistake is a terrible mistake—as opposed to some of the other sexually-transmitted diseases, not including herpes, not including other viral diseases, but syphilis and gonorrhea where this now, at least, some recourse if one fails.

So that we will I don't think ever say that this is a safe thing to do. This is a way of increasing one's safety. But there are relatively few absolutes, and this certainly isn't one of them.

Mr. SIKORSKI. Bear in mind, the return to the conclusion, abstinence is the one single, safe way.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you.

I'd like to ask a few other questions. You mentioned something about a prohibition of the Public Health Service of getting a message on prime time television, when, of course, most viewers are watching.

Is that because they won't allow the Public Health Service to buy the time or because they don't run public service announcements for free at that time?

Ms. OSBORN. I think it's because they won't allow the Public Health Service to buy the time. But as I mentioned, my information is quite casual; it's not expert. And so I would be delighted to see that it was followed through on to get the exact facts. I'm only privy to the commentary that the U.S. Public Health Service cannot buy prime time, and I think it's in the context of buying it.

Mr. WAXMAN. Well, we certainly want to hear more about that.

Assuming that the Government could buy time, that time would be very expensive. Right now, when you require the licensees, the television stations, to run public service announcements, which they do, they run those public service announcements very early in the morning, or very late at night. The viewer audience is very low.

Now if we wanted to get a message out—and we feel, on behalf of the Government of the United States, that in order to protect the public health of our people that we've got to get a message out to people about this terrible disease—is there anything inconsistent with having that information be given out by someone who stands to profit, through advertising, by the message? Is there anything inconsistent with advertising in conjunction with a campaign by the Government to get a broader message out to the American people?

Ms. OSBORN. I don't see any intrinsic inconsistency. As I said, I think that the content of the advertising message needs to be aligned with the facts, so that it doesn't make false promises. But those processes are in place, I'm sure.

Mr. WAXMAN. Well, it seems to me that the networks or television stations could consult with the Public Health Service of the United States Government and talk to their advertisers and say, "Well, we want ads only that communicate messages in a way that we find acceptable." They censor ads—you wouldn't believe it, but they censor ads all the time. They keep advertisers within some kind of check as to what they consider good taste.

But right now the policy is that the networks are deciding what message the public will get through their conclusion that most people are going to be offended by an advertisement promoting the sale of a condom.

From a public health point of view, should we let the networks decide what public health messages ought to reach the American people?

Ms. OSBORN. I think that we need to do everything we can to encourage all components of society to get into this one. It's a big campaign we've got to have. There's room for the networks to change their stance. I can understand where they're coming from, because people——

Mr. WAXMAN. But from a policy point of view, we shouldn't leave it up to the networks to decide these questions. We have a public interest that is broader than their own notion of what is in their particular interest and what they think the public taste will demand.

Ms. OSBORN. Let me get to your point here. I think that——

Mr. WAXMAN. Just very briefly, because there are several other points I want to make with a limited time.

Ms. OSBORN. A few months from now, it would be easy to persuade them, because the magnitude of the epidemic will get that much greater, and the issue will become——

Mr. WAXMAN. The magnitude of the epidemic is already great. People are dying, and we know that it's going to get worse.

Ms. OSBORN. My point is, I think we must do everything now that we can, because those few months are too expensive. I completely agree with you that this is an available means that we could take up now and deal with that would accelerate our ability to control the epidemic. So I am in full agreement.

Mr. WAXMAN. If the Government decided that we should be the one to put the ads on exclusively, that will require an expenditure of larger sums of money than I've seen this administration and even Congress willing to spend.

But let's say the Government were to decide on the message. Now we've known about this AIDS epidemic for years, and we've known that the best way to stop the spread of AIDS is through a clear public message. And yet we've seen quibbling within the administration as to how much of an emphasis should be put on abstinence versus other kinds of strategies. The moralists in the administration are fighting the Public Health people. And they're wasting precious time.

Now they've fought this out over months and maybe years when the message could have gotten out to people earlier: "You've got to protect yourself, because we don't have a vaccine to protect you from the spread of AIDS."

I raise these points because there are those who think maybe the Government should take on a greater burden. Government must take this burden on. I think we have to look at how well we've handled the problem so far and the questions that still remain. When we realize that during the period time when these fights have been going on within this administration, many people just didn't get the information they needed, and the disease has been spread much further than otherwise would have been the case.

My last point in the few seconds I have left in this round of questioning is not that we need to do one thing as opposed to another. Your message is very clear. Let's get the Government's public health message out. At the same time, let's let the condom manufacturers advertise within a certain range of what would be acceptable and in good taste, and do so in consultation with the Public Health people's recommendations as to what kind of a message would be appropriate or inappropriate.

Thank you very much.

Mr. Dannemeyer, do you wish a second round?

Mr. DANNEMEYER. I do.

Isn't the most important tool that public health officials use in dealing with communicable disease the fact that public health officials know the extent of the problem, specifically that those who have the disease are reported to public health authorities? Isn't that basic to the whole concept of public health control in this country?

Ms. OSBORN. I would say offhand that the most important role we have to play in this epidemic is education, sir.

Mr. DANNEMEYER. No, I'm talking about—I'm talking about the general role of public health in dealing with communicable disease. At the bottom of the whole pyramid of dealing with it is reportability, isn't it?

Ms. OSBORN. I wouldn't necessarily agree with that statement, but it would take a long time to——

Mr. DANNEMEYER. It takes place, doesn't it?

Ms. OSBORN. In the context that you're asking about, it takes place in sexually-transmitted diseases. In general, in terms of—I think you're inferring——

Mr. DANNEMEYER. Isn't it a fact that in the way our people, our society, has dealt with sexually-transmitted diseases, venereal diseases, is they're reportable?

Ms. OSBORN. I think that is a way they've dealt with them. I also point out that we have experienced a sexually-transmitted disease epidemic because it is an ineffectual way to deal with it.

Mr. DANNEMEYER. If that is the case—and I think you agree with me, that reportability of sexually-transmitted diseases is fundamental to dealing with them—why does that policy exist?

Ms. OSBORN. I think it comes out of the history of a time in which we had very little science to go with our awareness of what was going on. I think we are very fortunate in the context of this particular pathogen, that our science gives us quite a lot of information. We may well want to discuss further, when we have a treatment or cure,——

Mr. DANNEMEYER. Are you advocating at this point that we abolish the requirements for reportability of sexually-transmitted diseases?

Ms. OSBORN. No. I'm saying that——

Mr. DANNEMEYER. Well, if you agree—wait—if you agree that they exist, that they have a real reason for existence, then the question I have for you and any other members of the public health world today: Why have you in the public health world establishment set up a completely different standard for dealing with the virus for AIDS than our society has dealt with dealing with sexually-transmitted diseases generally?

Ms. OSBORN. I think, as Dr. Koop mentioned, AIDS is a reportable disease, sir.

Mr. DANNEMEYER. AIDS is a reportable disease, but not the virus. A person who has the virus—isn't it true that a person who has the virus has a non-curable communicable venereal disease? Isn't that a correct statement?

[Pause.]

Mr. DANNEMEYER. I'll say it again. Isn't it true that a person with the virus has a non-curable communicable venereal disease? Isn't that a correct statement?

Ms. OSBORN. To the extent that we know, it is potentially communicable, and it is certainly not curable; that's correct.

Mr. DANNEMEYER. Then why do we have the rationale that I think you're saying in response to Mr. Tauke's question, that you're defending the fact that we don't report those with the virus, yet for every other communicable disease, we do report it?

Why do you attempt to justify that?

Ms. OSBORN. Because I have a much greater urgency to handle this epidemic, and our dealings with earlier parts of the sexually-transmitted disease epidemic have been ineffectual. I think we already have evidence in this epidemic that the voluntary cooperation of people who have already been caught up in the path of this virus is far more likely to be quickly effective than any autocratic approach we can take to people who are carriers.

I think their voluntary cooperation is going to be far more valuable to us than any outcome that we can anticipate from mandatory tracing.

Mr. DANNEMEYER. And at that point, aren't you treating the issue as a civil rights issue and not as a public health issue?

Ms. OSBORN. No. I'm treating it as both, as I mentioned before. I do not——

Mr. DANNEMEYER. I disagree with you. You know, the State of Colorado has made those with the virus reportable for the last few years, and their chief health officer has made very clear in public statements that he has uttered, they feel that making the virus reportable is the most fundamental step that our society can take in terms of controlling the epidemic that we're facing in this country.

Ms. OSBORN. Yes, I know Dr. Vernon, and I've heard his statements, and I respect his judgment.

However, the reason you are citing the State of Colorado is that it's almost alone in that stance among the States.

Mr. DANNEMEYER. It's about—there's about half a dozen States in the Union where the virus is reportable; isn't that true?

Ms. OSBORN. The State—various State responses to the epidemic are changing, but at the moment almost all of them take a stance that is quite different from Colorado's, by my latest information, which was not this past week or so. There is quite a rapid state of change. But last I knew, Colorado was quite unique.

Dr. Vernon takes that stance, as do his public health officers, out of a very well-founded conviction of his reading of the data, but it does not correspond to the readings of the committee that I probably represent here, the Institute of Medicine, National Academy of Sciences. The position I've taken, I think, is representative of the best judgment of that group of people.

Mr. DANNEMEYER. When you talk, as your committee has, about the necessity of developing direct or vernacular explanations for the use of advertisements for condoms, don't we run into a little bit of a problem with respect to disseminating that kind of a message nationally from our network locations centered in the big media centers?

We reflect the value system of New York and Los Angeles and San Francisco. Those three cities contribute 70 percent of the AIDS cases in the country.

Ms. OSBORN. That won't last.

Mr. DANNEMEYER. And if we're going to let those three cities and their mentality control this message, aren't we going to have a little bit of an offensive reception by people in Little Rock, Arkansas or people down in Georgia or up in Montana with respect to the message that they're getting on their tube.

Mr. WAXMAN. The gentleman's time has expired. If you would care to answer the question briefly, please do.

Ms. OSBORN. Yes. I think the section that you've picked up on was our effort to urge—I had something to do with the wording of that section—it was our effort to urge communities to deal with their own version of the problem. So the use of the term "vernacular" was intended to suggest exactly what you're saying. You can't do that effectively from a national forum, so each of these pieces has to be done rationally with the intent of mobilizing every part of society in this context.

Communities have a terribly important role, and subsections of communities do too. And the vernacular will get more and more specialized as you go. It would be a great mistake to try and use the vernacular of a particular neighborhood of Los Angeles in order to communicate to somebody in Idaho.

But we have a common message which can be transmitted on a national medium.

Mr. WAXMAN. Thank you.

Mr. Tauke, do you wish additional questions? The gentleman is recognized for 5 minutes.

Mr. TAUKE. Thank you, Mr. Chairman.

First, I have to observe, I guess, somewhat in response to your observations, Mr. Chairman, that I think no matter how mightily the stations or some others may attempt to control the message that is offered by advertisements for condoms, I have to believe that if condom manufacturers are putting those advertisements on the air, the message is going to be, one, abstinence is out of date, and two, contraceptives offer more attractive possibilities.

Clearly, if there were abstinence on the part of a significant portion of the population, that would not be something that the condom manufacturers would desire, because their business dictates otherwise.

Mr. WAXMAN. Would the gentleman yield to me?

Mr. TAUKE. That's why I have concern about the—not the message; I don't have concern about the message being sound. I think it should be. I am concerned about who is sending the message and the motivation behind it.

Yes.

Mr. WAXMAN. Well, I appreciate what you're saying, and in a short while, we'll even show some of the condom ads that have been aired on television in this country. And I think you will agree that the message in those advertisements is not to increase the use of condoms through a kind of casual attitude toward sex. So I think the ads would be considered responsible ones.

I think that we want ads to be responsible. But after all, the condom manufacturers are going to make some money out of this epidemic, because the fact is, as people turn to condoms as the one way of protecting themselves from the transmission of AIDS, if they're going to have sexual activities. They don't have to hype it in order to attract more of a marketshare. They are simply the beneficiaries of this terrible tragedy, just as the pharmaceutical manufacturers are going to be beneficiaries when they develop drugs to stop or treat the disease.

Mr. TAUKE. If I may reclaim my time, I do want to pursue another set of issues with our witness, if I may.

I recall when I was in grade school, polio was the health problem of the time. There was a lot of education in the schools, education in a variety of public forums, relating to the spread of polio and what you did to protect your children, and there was a scare, as you know.

Is there something we can learn from that? It occurs to me that there isn't much happening in the schools or in many other places in our society that we usually rely on to educate people.

Ms. OSBORN. Well, I think we do need to be active in the schools, and so I think the central part of your question, I agree that we should be able—we should be in that mood at the very least, to try and make sure that this becomes part of the parlance of our society in very important ways.

There is a—it's hard to be optimistic and upbeat in this epidemic, but your example is one I like to use sometimes, because we're in a much better situation now with AIDS than we were at the time you are recalling. I, too, remember the discussions of polio.

And the point of the matter is that science was not as far along then with respect to polio as it is now with respect to AIDS. So we had to do our best with relatively insecure messages and very broad, sweeping messages that really made a difference to people's day-to-day lives, in broad contexts of their lives. You didn't go to swimming pools. You didn't do a lot of things that in retrospect were sort of scattershot efforts to avoid a virus that couldn't be avoided absolutely by behavior.

The wonderful message of AIDS, the only good news, is that this virus can be avoided by a person who makes some decisions about behavior. And that's the basic thing that we can educate. We don't even have to be very broad about what activities allow you to avoid the virus. Sex and drugs, for the school-age children, are two very dangerous aspects of this epidemic. But we don't have to worry about swimming pools and things like that that made polio such an unpopular message.

Mr. TAUKE. How did we get the message out in the polio era?

Ms. OSBORN. Very badly. It's very interesting to realize that when the polio vaccine was first available, there was a great deal of difficulty getting people to use it. Now we look back on the good old days of polio as if that had been an instant success. But one of the first frustrations at the time was that once that wonderful success had been achieved, you couldn't get people to come to the clinics and get the vaccine. That was a luxury we shouldn't have afforded then, but polio is a very difficult virus disease. For every 100 people infected, only one becomes paralyzed. By and large, they recover. So it's a very small fragment of the epidemic mass that ends up with even durable trouble.

Now we've got a life-or-death issue. We've got very narrow behaviors that need to be avoided. And then one can teach that you can make a personal decision to avoid this virus. No epidemic has ever been like that, and we must say so loud and clear, using every vehicle that we can find to say so.

Mr. WAXMAN. Thank you, Mr. Tauke.

Mr. Sikorski, do you wish to ask additional questions.

Mr. SIKORSKI. Thank you, Mr. Chairman.

Mr. WAXMAN. The gentleman is recognized for 5 minutes.

Mr. SIKORSKI. Underlying the discussion here this morning—is, one, I've noted, a real distrust of the market system.

Ms. OSBORN. That's ignorance, sir.

Mr. SIKORSKI. Not yours. I've heard real concern expressed for the free-market system in expectation that the marketers of these products would not be responsible, or that if these products were allowed to be advertised, that there would be no guidelines established to underscore the one safe method, abstinence, and I think we're going to see advertisements that do underscore that.

Beyond that, I think I share the concerns that have been expressed that we not allow, if we do have advertising, not allow the hyping of sex through condoms as a way of prevention, but I point out to everyone that we do not prohibit advertising, everything from tires to bathroom tissue, using sex appeal.

One can make the argument that virtually every 30-second ad during prime time, which has an appeal to sex, is countermanding the message that we want our kids and everyone in the society to appreciate with regards to AIDS and morals and a host of other things.

Do you appreciate that as well?

Ms. OSBORN. I certainly do.

Mr. SIKORSKI. Thank you, doctor. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Sikorski.

Ms. Osborn, you've been a terrific witness today. I thank you very much for your presentation to us and your forthright answers to all the questions we've had for you.

Ms. OSBORN. Thank you. I appreciate being here.

Mr. WAXMAN. The third panel of witnesses comprises representatives of the three national television networks.

Ralph Daniels is Vice President for Broadcast Standards with NBC, Incorporated.

CBS is represented by George Dessart, who is Vice President for Program Practices.

And Alfred R. Schneider with Capital Cities/ABC, Incorporated is Vice President for Policy and Standards.

If the three of you would please come forward at this time.

We welcome the three of you to our hearing today. We have your prepared statements and those statements will be made part of the record in full. We would like to ask you to summarize the statements in no more than 5 minutes.

Why don't we start with Mr. Daniels.

STATEMENTS OF RALPH DANIELS, VICE PRESIDENT, BROADCAST STANDARDS, NATIONAL BROADCASTING CO., INC.; GEORGE DESSART, VICE PRESIDENT, PROGRAM PRACTICES, CBS/BROADCAST GROUP; AND ALFRED R. SCHNEIDER, VICE PRESIDENT, POLICY AND STANDARDS, CAPITAL CITIES/ABC, INC.

Mr. DANIELS. Thank you, Mr. Chairman. I am Ralph Daniels, Vice President of Broadcast Standards of the National Broadcasting Company. I am pleased to appear before this Subcommittee today to discuss NBC's policies relating to the acceptance of paid

advertising of condoms in the context of public health issues surrounding the disease known as Acquired Immune Deficiency Syndrome.

Like all Americans, NBC is concerned about the spread of this fatal virus. We were among the first broadcast organizations to focus public attention on and provide information about AIDS. In fact, even before it had come to be known by that name, NBC presented the first network report on this disease.

Beginning in 1982, we and many other media have consistently covered all aspects of the emerging story about AIDS. NBC's news and public affairs programming has provided our viewers timely and important information, including the origins of the disease, the risk factors, treatment options, available testing and detection, and perhaps most importantly, the best available information on prevention. This has included information about the role condoms can play in reducing the risk of infection.

During the last 2 years alone, NBC has presented over 350 separate news stories and public affairs reports on AIDS. We have also presented two hour long news special reports in prime time devoted solely to this subject.

In addition to news and public affairs programming, we have presented some dramatic programs dealing with this subject, including the award winning television movie, "An Early Frost," and episodes of our regular dramatic series, "St. Elsewhere, Hill Street Blues, and L.A. Law." Such programming has elicited both criticism and praise from our viewers because of complex social, religious and moral issues involved.

We believe that as a company, we have made a substantial and continuing contribution towards presenting valuable and useful information for our audience on this important public health issue.

However, it has long been NBC's policy not to accept paid product advertising promoting the sale and use of condoms. For over 50 years, NBC has had standards for acceptance of advertising. Our television network standards reflect the fact that we provide a program service to over 200 individual television stations serving local communities across the Nation. The audience served by these stations include a wide range of religious beliefs, social attitudes and mores, as well as local and regional concepts of propriety and acceptability.

We must consider all of these factors in making decisions about the content of our programming and our advertising.

Our experience has told us that some types and categories of advertisements are unacceptable to a significant portion of our audience, simply because of the subject matter. NBC does not accept broadcast advertising for a number of general product categories. These include all birth control devices, including condoms, as well as such other products as hard liquor, firearms, "X" rated movies and others. We also do not accept commercials which present what we consider to be unacceptable sales approaches.

The question of whether to accept condom advertising raises complex issues. As a birth control device, such ads are offensive to segments of our audience on moral or religious grounds. Other viewers believe that condom advertising in any context inherently delivers a message about sexual permissiveness, which they find

objectionable. Still other viewers regard condom advertising as a potentially effective way to combat the spread of the AIDS virus.

The recent discussion about condoms and AIDS virus has focused new attention on traditional broadcast policies against acceptance of condom advertising. Broadcast network or local stations cannot ignore the fact that condoms are also contraceptive devices. We have to weigh all these factors in examining the question of condom ads.

Our management is well aware of these complex and competing interests. We are sensitive to the concern about disease prevention, to the attitudes and opinions of those who object to such ads on religious, moral or social grounds, and to the perception of our affiliated stations.

The whole process of broadcast standards is an evolving one. We adjust our standards from time to time to reflect changing audience values and sensitivities.

Concern over the AIDS virus is a factor which may be influencing the opinions of many about condom advertising. The fact that other media and individual television stations have begun to accept such advertising for the first time, may accelerate these opinion changes.

We commend this subcommittee for providing a forum for a range of views and information on this complicated question.

While we are continuing our policy that condoms are not acceptable as product advertisements, we are monitoring these arguments and attitudes. We will continue to discuss and review this issue both internally and with our affiliated stations. Through our overall program service, we will continue to present public health information on AIDS.

Mr. WAXMAN. Thank you very much, Mr. Daniels.

Mr. Dessart.

STATEMENT OF GEORGE DESSART

Mr. DESSART. I am indeed George Dessart. I am Vice President, Program Practices, for the CBS Broadcast Group. As such, my responsibilities include the review of commercial announcements for their acceptability for broadcast on the CBS Television Network.

We appreciate this opportunity to appear before this Subcommittee today as you consider the question of condom advertising as it relates to the AIDS epidemic.

At the outset, may I suggest that there is a necessity to differentiate between two issues which have somehow become intertwined in the current debate. The public information issue is quite separate and distinct from the question as to whether the CBS Television Network should or should not accept advertising for a particular product category.

Let us this morning first turn our attention to the way in which CBS has responded to the American public's need for accurate and comprehensive information about the disease.

Over the last 4½ years, CBS news coverage of the problem has increased in direct proportion to the knowledge gained and the information available. In 1982, there were three stories. In 1986, 194. In 1987, there have already been 47 reports, more than one each

day. From the time of that first story until yesterday, CBS News alone has broadcast approximately 500 AIDS related stories.

For example, on October 22, 1986, when the Surgeon General's Report was issued, CBS News presented a special broadcast with Dan Rather from 8 to 9 p.m. entitled "AIDS Hits Home." More recently, on January 22, during its second week on the air, CBS' newest information broadcast, "The Morning Program," carried an extensive presentation with Dr. Robert Arnot, regarding the role of condoms in preventing sexually transmitted diseases, with a special focus on AIDS.

Entertainment programs have also incorporated significant references to the problem. For example, a "Cagney and Lacey" episode broadcast last December, dealt with teenage sexuality and responsibility with specific reference to the importance of condoms. CBS Entertainment also has several projects in various stages of development dealing with AIDS through programs in the afternoon "Schoolbreak Special" series, dealing forthrightly with the disease.

A most significant vehicle, as has been mentioned here this morning, is the Public Service Announcement or PSA. In addition to the news and information broadcast they have carried on various aspects of the AIDS epidemic, the CBS owned AM, FM and television stations have been broadcasting PSA's in support of AIDS research or for local information sources, clinics and other facilities.

Public Service Announcements should provide, we believe, a particularly effective means for informing the public on AIDS prevention. Unfortunately, announcements geared to the national audience have been slow in coming. In large measure perhaps because the available information on AIDS was changing so rapidly and materials to which a national audience might be referred, simply were not available. This is no longer the case.

We understand that announcements on prevention are being readied by several organizations, although to date, we have received none which we can place in our schedule.

In the meantime, CBS has produced on its own initiative several Public Service Announcements which point out how AIDS is transmitted and that it is preventable. Viewers were referred to their physicians or to the AIDS hotline for a booklet prepared by the U.S. Public Health Service.

These announcements were first shown last week and are now scheduled in virtually every day part, including prime time. It is our intention to augment them with other announcements, including some featuring the Surgeon General, which we believe will soon become available.

We have also met with the American Medical Association and are looking forward to receiving Public Service Announcements submitted by them as well.

Having looked at some of the efforts we have been making to address the information issue, let us now turn to the question of condom advertising and the concerns that raises for us.

This is a very sensitive issue involving the most deeply held personal values. We note that there are currently 1,227 commercial television stations in the United States. Yet by late last week, individual local television stations in only 11 markets had chosen to

accept condom advertising. Their managements have made those decisions based on intimate knowledge of their own communities. It is reasonable to expect that other stations may elect to do the same, but only as their managements are secure in their assessment of attitudes in their own communities.

That is consistent with their obligation as licensees; their judgment as local business people; and their sense of responsibility as professional broadcasters. For, as we all know, community standards and the extent of public health concerns vary greatly from locality to locality.

The CBS Television Network reaches a very diverse audience nationwide. Its programs and its commercials are carried by more than 200 local stations. In making decisions on program or commercial content, we must keep in mind that we serve as a surrogate for local licensees. Those licensees, our affiliates, represent all kinds of communities.

That is the crux of our problem. We at CBS believe it is essential that we give our affiliates time for a reasoned judgment. As recently as last week, in the third of a series of regional meetings with our affiliates, we discussed the question of condom advertising. Frankly, the signals we received are mixed.

Some of our affiliates are convinced that condom advertising would be totally inappropriate in their communities. Such commercials, they believe, would be perceived as intruding upon deeply personal matters and being gratuitously offensive to a large portion of their audience. Some tell us that not only would they decline such commercials submitted for local broadcast, they would also refuse to transmit any which appeared on the network. Others seem to believe that public opinion is in such a state of flux on this issue, that it is impossible to make a determination in their communities at this time. Some are worried that acceptance of such advertising might be perceived as capitalizing on a disaster. Some, however, are giving serious and active consideration to accepting commercials for condoms.

As a national broadcasting medium, we must obviously take into account all of these factors in considering an issue as uniquely sensitive as this. At the present time, we are not yet persuaded that a change in our network policy is indicated. However, the American public is clearly in the midst of an educational process and a reevaluation of attitudes with respect to the AIDS epidemic. I can assume you that we will be watching that process very closely as we continue to consider this issue.

Meanwhile, CBS believes it can best discharge its sense of responsibility in this most serious matter by continuing the kind of informational efforts we have described. The need for public health information has never been greater. We will take every appropriate step to help meet that need.

Mr. Chairman, members of the subcommittee, I wish to thank you for your courtesy in permitting me to discuss CBS' position and to share with you our efforts to date in communicating information on the AIDS problem.

[The prepared statement of Mr. Dessart follows:]

STATEMENT OF

GEORGE DESSART

VICE PRESIDENT, PROGRAM PRACTICES

CBS/BROADCAST GROUP

My name is George Dessart. I am Vice President, Program Practices for the CBS/Broadcast Group. As such, my responsibilities include the review of commercial announcements for their acceptability for broadcast on the CBS Television Network. We appreciate this opportunity to appear before the Subcommittee today as you consider the question of condom advertising as it relates to the AIDS epidemic.

At the outset, may I suggest that there is a necessity to differentiate between two issues which have somehow become intertwined in the current debate. The public information issue is quite separate and distinct from the question as to whether the CBS Television Network should or should not accept advertising for a particular product category.

Let us, this morning, first turn our attention to the way in which CBS has responded to the American public's need for accurate and comprehensive information about the disease.

To the best of our knowledge, the medical profession first publicly acknowledged the existence of the emerging disease we now know as Acquired Immune Deficiency Syndrome in the June 5, 1981 Morbidity and Mortality Weekly Report of the Center for Disease Control. The name AIDS did not appear in that report until September 3, 1982, a month after THE CBS EVENING NEWS WITH DAN RATHER began in-depth

reporting on the disease. Since August 2, 1982, CBS News has consistently presented the most current and accurate information on the nature and etiology of the disease; the early identification of high risk groups; the effects of the disease upon its victims; efforts to develop vaccines and/or cures; other efforts to check the spread of AIDS; and the implications of the developing epidemic for the society as a whole.

Over the last four and one half years, CBS's coverage of the problem increased in direct proportion to the knowledge gained and the information available. In 1982, there were three stories; in 1986, 194. In 1987, there have already been 47 reports -- more than one each day. From the time of that first story, until yesterday, CBS News alone has broadcast approximately 500 AIDS-related stories.

In addition to news reports, AIDS has been the subject of numerous special reports, discussions and documentaries dating back to an August, 1983 broadcast of OUR TIMES WITH BILL MOYERS. During the same month, FACE THE NATION first addressed the issue. NIGHTWATCH had devoted 18 segments to the topic including five half-hour interviews. On May 7, 1986, WEST 57TH STREET reported on the tragedy of children with AIDS. 60 MINUTES had done four different stories on various aspects of the disease. On October 22, 1986, when the Surgeon General's Report was issued, CBS News presented a special broadcast from 8 to 9 PM entitled "AIDS Hits Home."

More recently, on January 22, during its second week on the air, CBS's newest information broadcast, THE MORNING PROGRAM, carried an extensive discussion with Dr. Robert Arnot regarding the role of condoms in preventing sexually transmitted diseases, with a special focus on AIDS.

Entertainment programs have also incorporated significant references to the problem. Among these have been the TRAPPER JOHN M.D. episode of November 3, 1985, which dealt with some of the questions arising when a nurse's former boyfriend is diagnosed as having AIDS.

The long-running daytime serial, AS THE WORLD TURNS, has, since October, been including a story-line reference to AIDS on an approximately weekly basis. While her husband, Dr. David Stewart, is in Africa doing AIDS research, his wife, Ellen, has been doing community consciousness-raising.

Not specifically addressed to the AIDS issue, but certainly relevant to our concern this morning, was the CAGNEY & LACEY episode broadast on December 1, 1986 and entitled "Rites of Passage," during which Detective Lacey discussed responsible teenage sexuality. In talking with her husband about their son's sexual awakening, Mary Beth specifically mentioned the importance of condoms.

CBS Entertainment has several projects in various stages of development dealing with AIDS. Two programs in the highly acclaimed series addressed to high school and junior high school-aged youngsters, the afternoon SCHOOLBREAK SPECIAL series, deal forthrightly with the disease. "What If I'm Gay?," which includes discussion of the special risks homosexuals face, is scheduled for broadcast March 31. "The Enemy Among Us," the subject of which is AIDS itself, is being readied for later presentation.

A most significant vehicle is the public service announcement or PSAs. In addition, the news and information broadcasts they have carried on the various aspects of the AIDS epidemic, the CBS Owned AM, FM and television stations have been broadcasting PSAs in support of AIDS research, or for local information sources, clinics or other facilities.

Public Service Announcements should provide, we believe, a particularly effective means for informing the public on AIDS prevention. Unfortunately, announcements geared to the national audience have been slow in coming, in large measure because the available information on AIDS was changing so rapidly and materials to which a national audience might be referred simply were not available.

That is no longer the case. We understand that announcements on prevention are now being readied by several organizations, although to date we have received none which we can place in our schedule. In the meantime, CBS has produced, on its own initiative, several public service announcements which point out how AIDS is transmitted and that it is preventable. Viewers are referred to their physicians or to the AIDS hotline for a booklet prepared by the United States Health Service.

These announcements were first shown last week and are now scheduled in nearly all dayparts, including prime time. It is our intention to augment them with announcements featuring the Surgeon General, which we believe will soon become available. We have also met with the American Medical Association and are looking forward to receiving public service announcements submitted by that organization as well.

Having looked at some of the efforts CBS has been making to address the health issue, now let us turn to the question of condom advertising and the concerns which that raises for us.

This is a very sensitive issue involving the most deeply held personal values. We note that there are currently 1227 commercial television stations in the United States. Yet by late last week, individual local television stations in only eleven markets had

chosen to accept condom advertising. Their managements have made those decisions based on intimate knowledge of their own communities. It is reasonable to expect that other stations may elect to do the same -- but only as their managements are secure in their assessment of attitudes in those communities. That is consistent with their obligations as licensees, their judgment as local business people and their sense of responsibility as professional broadcasters. For, as we all know, community standards and the extent of public health concerns vary greatly from locality to locality.

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Some of our affiliates are convinced that condom advertising would be totally inappropriate in their communities. Such commercials, they believe, would be perceived as intruding upon deeply personal matters and being gratuitously offensive to a large portion of their audience.

Some tell us that not only would they decline such commercials submitted for local broadcast, they would also refuse to transmit any which appeared on the network.

Others appear to believe that public opinion is in such a state of flux on this issue that it is impossible to make a determination in their communities at this time.

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Some, however, are giving serious and active consideration to accepting commercials for condoms.

As a national broadcasting medium, we must obviously take into account all of these factors in considering an issue as uniquely sensitive as this. At the present time, we are not yet persuaded that a change in our network policy is indicated. However, the American public is clearly in the midst of an educational process

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Mr. Chairman, members of the Subcommittee, I wish to thank you for your courtesy in permitting me to discuss CBS's position, and to share with you our efforts to date in communicating information on the AIDS problem.

Mr. WAXMAN. Thank you very much, Mr. Dessart.
Mr. Schneider.

STATEMENT OF ALFRED R. SCHNEIDER

Mr. SCHNEIDER. Mr. Chairman and members of the Committee, my name is Alfred Schneider. I am Vice President for Policy and Standards of Capital Cities/ABC, Inc. The Department of Standards and Practices, which reviews all entertainment programming and commercials prior to broadcast, reports to me.

One of my responsibilities in this regard is to ensure that ABC Television Network's programming and commercial meet standards of good taste and community acceptability. We undertake this task because of the special nature of broadcast television, which is an invitee into millions of viewers' homes.

Unlike a newspaper, book or a magazine or cable television, where an affirmative decision to purchase is involved, we are present in 99 percent of American homes with television, instantly available to all at the flick of a switch.

Of all the communications media, television is the most personal, immediate and far reaching. Given the broad diversity of our national audience in age, education, social value and mores, broadcast television demands special care and responsibility. We pay careful attention to those needs, those wants and those concerns of our viewers, and attempt to be responsive by monitoring viewer reaction, analyzing public opinion research and holding meetings with a variety of special interest groups and organizations.

Our objective is to provide programming which is considered acceptable and appropriate by a diverse mainstream audience. This objective expands to our policy regarding the review and acceptance of advertising as well.

The issue regarding acceptance of contraceptive advertising goes to the heart of these concerns. Such advertising clearly raises complex moral, ethical, and religious questions, which can be difficult to address or resolve satisfactorily in a 15 or 30 second commercial.

Furthermore, a significant portion of our viewers feel contraceptive commercials are inappropriate or offensive, because they appear within or adjacent to programs that they may be viewing with their families, and these commercials appear without warning and out of context. These concerns have been the basis for our long standing policy against carrying such advertising on the ABC Television Network.

Let me stress that as we analyze these difficult and sensitive issues of commercial acceptance, we are required to play the role of surrogate for over 200 affiliated stations representing over 200 individual markets, markets with widely varying mores, attitudes and values.

In the final analysis, it is the local station licensee that makes the decision to carry any commercial or program. It is the local station that has the knowledge and understanding of the community it serves and it is the local station that is in the best position to determine what constitutes operating in the public interest, convenience and necessity on sensitive issues in its own community. Accordingly, we have treated the issue of contraceptive advertising

as an issue which rests with these local stations and local options. Until very recently, our affiliates have by and large concluded that they will not accept such advertisements.

Before I turn to the very recent developments in the commercial acceptance area, let me state that our policies on contraceptive advertising do not apply to programming. Our entertainment, information and news programming have addressed the issues regarding contraception, sexuality and health concerns.

In that regard, let me specifically mention one program, a 2 hour made for television drama, tentatively entitled "Daddy," which is scheduled to appear on the ABC Television Network this coming Spring. The program will deal frankly with the issue of unintended teenage pregnancy and it discusses issues of sexual behavior, contraception and personal responsibility in a frank and candid manner.

The program is both realistic and relevant to teenagers and to adults who are naturally concerned about the social problem. We hope this is a program which will be viewed by both parents and their teenagers and that it will stimulate a discussion among parents and their children about issues surrounding teenage sexuality, within the context of a family's personal lives and personal values.

I am providing an attachment which details additional examples of broadcasts in 1986 and other years that are available, if you desire.

As we see it, the difference between programming and commercials is that programming offers the opportunity to discuss complex social moral concerns in depth and provides a context for doing so. Further, audiences can be made aware of the subject matter of the program and decide in advance whether or not to view them.

Commercials, on the other hand, offer neither the time, the context nor the possibility of advance warning to those who might not wish to watch such material.

The recent attention devoted to the AIDS epidemic has of course introduced a new concern. We have been asked to approve a broadcast for certain condom advertising which addresses the medical fact that the use of the condom may lower the risk of transmitting the AIDS virus.

Our position with respect to this issue is that while condoms may afford a measure of such protection against AIDS, it is impossible to separate this product use from the original and long standing use of the product, which is for birth control purposes.

Accordingly, acceptance of health related contraceptive advertisements for condoms necessarily means that we would soon be accepting a variety of contraceptive advertisements making a variety of product claims.

Nevertheless, as responsible broadcasters and as concerned citizens, we cannot fail to recognize the special responsibility which the AIDS problem may impose upon us. We are exploring whether we can develop and broadcast appropriate public service announcements with various agencies that consider the concerns I have outlined. We are paying close attention to the decisions being made by our affiliates and our own stations regarding the acceptance of condom advertisements.

As I have suggested, the local stations are, out of necessity, our weathervanes on issues such as this. We are and will be carefully reviewing and following their attitudes of all of American society with respect to this subject.

Thank you very much.

[Attachments to Mr. Schneider's prepared statement follow:]

GOOD MORNING AMERICA

2/10-2/13/86 — Topic: A four-part series on teenage pregnancy

(1) Overview and adult forum discussing the subject.
(2) A forum of teenagers discussed the problem.
(3) Mary Lee Tatum, a teacher of "family life" and sex education in Falls Church, Virginia.
(4) Solutions.

2/19/86 — Topic: The financial cost of teenage pregnancy epidemic.

Judith Senderowitz, former Director of the Center for Population Options.

3/5/86 — Topic: Contraceptives

Dr. William Ledger, Chairman of Obstetrics and Gynecology at New York Hospital/Cornell Medical Center

3/7/86 — Topic: Heterosexual transmission of AIDS

Dr. Tim Johnson, GMA Medical Editor

3/17/86 — Topic: The changing sexual climate

Dr. Theresa Crenshaw, President elect of the American Association of Sex Educators, Counselors and Therapists. Michael Callen, a victim of AIDS. Rita Casey, a 28 year old single.

3/21/86 — Topic: Pregnancy

Dr. Tim Johnson, GMA Medical Editor

4/4/86 — Topic: Sexually transmitted diseases

Dr. Tim Johnson, GMA Medical Editor, Dr. Mary Guinan, a doctor with the Sexually Transmitted Diseases Division at the Centers for Disease Control.

5/28/86 — Topic: AIDS Research Funding

Dr. Mervyn Silverman, President of the American Foundation for Aids Research

6/3/86 Topic: The N.I.H. sponsored study on women in their twenties, contraception and sexual activity.

Wendy Baldwin, a spokesman for the National Institute of Health. Fay Wattleton, President of the Planned Parenthood Association.

6/13/86 Topic: AIDS

Dr. Walter Dowdle, AIDS co-ordinator for the Public Health Service.

6/16/86 Topic: The impact of AIDS on casual sex.

Erica Jong, Author
Sandra Lee, a single woman concerned about contracting AIDS.

6/24/86 Topic: The second International AIDS Conference

Dr. Anthony Fauci, a specialist on AIDS at the National Institute of Health. Dr. David Klatzman, an AIDS specialist at the Pasteur Institute.

8/18/86 Topic: Acquired Immune Deficiency Syndrome (AIDS)

Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases and coordinator of AIDS research for the National Institute of Health. Dr. Margaret Fischl, Director of the Clinical AIDS Research Program at the University of Miami Jackson Memorial Medical Center. Dr. Peter Mansell, Director of the Institute of Immunological Disorders (Houston). Tim Sweeney, Executive Director of the Gay Mens Health Crisis

8/20/86 Topic: Sex and Marriage.

Dagmar O'Connor, a sex therapist, Ann Landers, syndicated columnist

9/4/86 Carol Lynn Pearson, a woman who wrote a book on her relationship with her former husband who died of AIDS.

9/8/86 Topic: Advertising "safe sex"

Fred Danzig, Editor of Advertising Age, Dr. Ruth Westheimer, sex therapist.

9/23/86 Topic: AIDS

Dr. Tim Johnson, GMA Medical Editor

10/27-31/86 Topic: Five-part series on AIDS

12/5/86 Dr. Jonathan Mann - Researcher in AIDS for the World Health Organization.

PROGRAMMING

Prime Time

DADDY (Scheduled for Spring 1987)

Made-for-television film which deals candidly with the issue of teenage pregnancy and the responsibilities which teenagers and their parents face in determining whether or not to become sexually active and the consequences of sexual activity.

CHOICES (February, 1986)

A drama dealing with choice facing two women who are unexpectedly pregnant. One has an abortion and the other does not and the program explored various issues surrounding sexuality, its consequences, and the controversy of abortion.

MR. BELVEDERE (November, 1986)

Teenage son Wesley wants to experience his first sexual relationship but in romancing the girl most likely to agree, realizes that sexuality requires a commitment and maturity that he is not ready to make at the time and changes his mind about the affair.

HEART OF THE CITY (Fall, 1986)

This series about a widowed police officer with two teenage children frequently dealt with issues regarding the children's sexual unfolding. In one episode, the father directly questioned his son about his use of contraception when the son revealed that he had his first sexual experience. Another episode dealt with the daughter's request for her father to approve her receiving birth control pills and the father's refusal to grant such permission. Issues regarding teenage sexuality, responsibility and the "double standard" were explored in this drama.

Afterschool Specials

CAN A GUY SAY NO? (February, 1986)

A teenage boy feels pressure to experience a sexual relationship but after he befriends the most "available" girl in school, realizes that sexuality requires more than merely reaching a certain chronological age and decides to wait until he is emotionally ready for the experience.

TEEN FATHER (November, 1986)

A show dealing with the consequences of unintended teenage pregnancy and subsequent responsibilities of child-rearing. The program depicted how "teenage parenting" irrevocably changes the lives of both mother and father and the serious difficulties the entire family will encounter.

71-373 0 - 87 -- 3

WORLD NEWS TONIGHT

3/6/86	Story:	Study shows AIDS may be transmitted in heterosexual relations.
3/13/86	Story:	New drug treatment may halt not cure AIDS.
4/10/86	Story:	Possible vaccine to prevent AIDS.
6/23/86	Story:	Justice Dept. says AIDS carriers can be fired from jobs.
	Story:	AIDS is spreading fast worldwide: possible treatment found.
8/25/86	Story:	Ryan White back in school; new hospital solely for AIDS.
8/26/86	Story:	Football star Jerry Smith reveals he has AIDS.
8/29/86	Story:	Transplanted donor's organs found to have AIDS antibodies.
8/30/86	Story:	AIDS and organs transplant; CDC test sabotaged.
8/31/86	Story:	Story: Legal problems surrounding AIDS.
10/7/86	Story:	Looks at Larouche's anti AIDS bill proposition 64
10/21/86	Story:	Look at increase in violence against homosexuals
10/22/86	Story:	Surgeon Gen. Koop advocates AIDS education for everyone.
10/29/86	Story:	Health experts stress importance of AIDS education.
	Story:	2-way with Dr. Thier on importance of AIDS education.
11/21/86	Story:	Aids epidemic in Africa.
12/16/86	Story:	Why condom commerciala are not shown on TV.

NIGHTLINE

6/30/86 AIDS and Justice Can AIDS victims be barred from working without violating their civil rights.

9/19/86 Coping with AIDS Interview with Ken Meeks - AIDS victim.

10/20/86 AIDS in Africa AIDS in the African Continent

1/9/87 Ribavrin and AIDS Test results.

1/21/87 Condom Advertising General Discussion.

1/30/87 New Insurance for AIDS General Discussion.

20/20

7/25/85 The Paris Treatment - Americans are going to Paris for treatment of AIDS. (Rock Hudson)

9/26/85 AIDS in the Heartland AIDS hits a small mid-western town.

10/3/85 What is AIDS Myths and Facts - general information

12/86 AIDS in the Blood Supply

1/1/87 Message Goes Pop Teenage Pregnancy in Latin America Music Video regarding chastity.

2/12/87 Safe Sex Discussions included protection and condoms.

Mr. WAXMAN. Thank you, Mr. Schneider. Before I direct my questions to the panel, I would like to call your attention to the screen over on the side of the room. I would like you and the rest of our audience to view two commercials.

[Commercials viewed.]

Mr. WAXMAN. Those are two ads that have run on some television stations. I want to ask the three of you: what is inappropriate about those two ads? How are these ads any more suggestive or explicit than the over 20,000 sexual encounters portrayed each year on your national programs or any more offensive than the various feminine hygiene items such as menstrual and vaginal deodorant products that you do advertise? Mr. Daniels, do you want to start?

Mr. DANIELS. I think the difference is, first of all, not with the content of the ad but the category itself and we as you know from my statement have said that that is not a product category that is acceptable along with a number of other product categories.

There are a number of things in your statement about the content of the programming which you find or submit that other people might find more offensive and we feel that we have a pretty good fix on the pulse of the country in the programming that we do do.

Our monitoring of that through special interest groups, through the press, through criticism, through audience reaction and phone calls, in the things they write to us indicate to us that we have a pretty good handle on what is acceptable.

A number of the polls that have been done in this general subject of condom advertising indicate a mixed reaction as each of us have said here today. So I think the door is still open.

We are still looking at that issue and it seems to be in a state of flux and a process of change.

Mr. DESSART. Yes. I would like to underscore that the question here is not a question of taste. The question as I indicated is at this point that the 200 stations or more for whom we serve as surrogate are by no means decided as to what they are able to willing in their mind to carry in their community.

Some would find these perfectly acceptable it would seem. Some, many would find them totally inappropriate for the reasons I earlier indicated.

Mr. WAXMAN. Mr. Schneider.

Mr. SCHNEIDER. There are two other points that I would like to raise. I think the first one to me has no question of offensiveness or inappropriateness so far as taste is concerned. What it does do, however, is raise indirectly the question of the use of the product as a birth control device. I think that is a separate issue which cannot be separated in terms of the acceptability of this product.

The other question, the citing of the statistics about sexually explicit programming, I know of no program on any network that I have seen that shows a sexual encounter if I literally accept the word "sexual encounter" in terms of the advocacy of intercourse.

What it may do is relate to the question of relationships between people but it is always within the context of the program itself, the drama itself, the consequences, the moral aspects, the immoral aspects of that behavior and whether or not it is a question of taste and whether or not one agrees or disagrees with the appropriate-

ness of that particular program or the taste question is certainly something that we hear about from our audience and that we have to be responsive to which I think is a separate and distinct question from the manner in which we are dealing with here.

Mr. WAXMAN. Let me put aside for a moment some of your comments about programming. Some aspects of your answers are pretty provocative could be discussed at length, but let's get back to the topic for today's hearing which is AIDS.

We know certain things about AIDS and I assume that you have no doubt about the magnitude of the AIDS epidemic. I also assume you are aware of the long and difficult task that lies ahead in finding a cure for AIDS or any vaccine to stop the spread of the disease.

It appears from the public health people that our only available and effective method of combating the AIDS epidemic is through public education, and if we can't discourage sexual activity through condom use.

Now I applaud what you have done when you have shown programming and news coverage of the AIDS epidemic. But the real question is, how much worse does this AIDS epidemic have to be before you will come to the conclusion that you have some leadership role to play as the managers of the three leading outlets for television communication in getting a message across to people other than what you may show on a news show or a special on the whole question of AIDS.

I guess that is a rhetorical question because I assume your response to me is going to be the same response you made in the original testimony.

But let me explore with you the question of whether you leave it to the local affiliates. Does each of you allow your local stations, affiliates, to run these ads if they choose to? Mr. Daniels.

Mr. DANIELS. Yes, we do. We have no control over that.

Mr. WAXMAN. Mr. Dessart.

Mr. DESSART. Our affiliates are independently managed and they are free to make their own determination.

Mr. WAXMAN. Mr. Schneider.

Mr. SCHNEIDER. The same is true with respect to ABC affiliates as well as Cap Cities/ABC owned stations.

Mr. WAXMAN. So each of those stations may, if they choose to run the ads, can go ahead and do it. Now one of the problems with that is even if they choose to do it, the networks preempt large blocks of time—what is called the prime time—when there is the largest viewing audience. You can reach more people with an ad during that time which, of course, is one of the reasons the networks are able to make a handsome profit by selling advertising space during prime time.

Let me ask you, if we look at the standards and opinions around the country—and Mr. Daniels, you specifically said that NBC adjusts its broadcast standards from time to time to reflect changing values and sensitivities—have you been aware of a recent January 1987 NBC/Wall Street Journal national opinion poll on the question of condom advertising?

Mr. DANIELS. Yes.

Mr. WAXMAN. That opinion poll said that a strong majority, 79 percent of the people questioned would approve of advertisements on the use of condoms as a way to help prevent the spread of AIDS.

Now if your own polls indicate that 79 percent of people are willing to have advertisements on television to combat AIDS, what more will it take for you to reflect on the changing values and sensitivities of the public and permit advertisements to reach the largest possible audience on network time?

Mr. DANIELS. When you say, "what more" we never do on any issue go to a single source. The context of that question was in a series of questions which in terms of methodology, our social research department indicates can guide the client advancers and therefore, percentages that you are going to receive from the respondents.

Put in quite a different context or series of questions, the answer can be different. We have seen and you have seen in the news and magazines and newspapers even recently quite different results. "Entertainment Tonight" a week ago was reported to have asked for a response on this same question and it was a 30,000/20,000 response; 20,000 against.

We are looking at this very seriously. I don't take lightly the research that our own NBC News Division has done, but I think we want to coordinate that with all the other resources that we can in coming to any decision about making any changes.

Mr. WAXMAN. Mr. Schneider.

Mr. SCHNEIDER. Mr. Chairman, just two comments. One is that unfortunately, we are not all making handsome profits in the television network. I think ABC and Cap Cities has disclosed this is not the case for this year nor is it expected for next year. Second, we did indicate that Public Service Announcements would be reviewed and found acceptable in terms of condom advertising and included in the schedule.

Obviously, as you pointed out before, there is a limitation in the amount of time that is available for Public Service Announcements.

Third, a local station can schedule such condom advertising if it so elects in prime time during local station breaks. There are local stations breaks available to those stations in prime time. It is in their discretion and subject to of course scheduling requirements, that there would be an opportunity for them to do so.

Mr. WAXMAN. First of all, your Public Service Announcements don't get much of an airing at times when people watch television. They are generally run when you do your generous bit for the public service, when you don't have advertisers clamoring for time. If you allowed prime time to be sold by the local affiliates, you are talking about a very, very limited amount of time.

Regarding your news coverage of the AIDS epidemic, can each of you tell me how much news time devoted to the AIDS story has specifically addressed the question of the use of condoms as a way to stop the transmission of AIDS? I don't know if you have that information. You probably don't. If you do, we would like to have it for the record.

I would suggest that the answer is probably once or twice in the last year. I think that is hardly a way to get a message across to

people and certainly not to the people who are most at risk or the people who don't read publications and who watch television for their main source of information. Most of them may not even watch the news shows.

Mr. Dannemeyer.

Mr. DANNEMEYER. The second ad was interesting. The inference is if you use a condom, you reduce your chance of getting AIDS. Now, some people will see that and a week from now will say to their friends, if you use condoms, you won't get AIDS. They will make that transposition. There is little doubt in my mind at all.

Given the litigious age in which we live, we sue one another at the drop of a hat. In fact, we start the suit even before the hat hits the floor. It is just a question of time, that we will go down this road of advertising to the American public that condoms can prevent people from getting AIDS, even though people use condoms, people are going to get AIDS, a small percentage of them. We don't know what percentage.

It is predictable that a class action suit will be filed by those persons who claim they got AIDS from sexual activity, notwithstanding the fact that their partners used a condom. They are going to name a class action on behalf of all persons similarly situated. They are going to name as defendants three networks, every affiliated station in America that has shown those ads, and then you will have the privilege of defending yourself, you know, for the litigation that will ensue. The claim will be made by the plaintiffs' lawyers. You can hear it now. The people of America were told to use condoms, they wouldn't get AIDS. A jury will have to decide.

Now, you will have imminent legal counsel advising your decision process as to whether or not you should accept advertisements of this type.

What is your response to what I have just postulated as likely to happen?

Mr. DESSART. I for one am not an attorney but I think, sir, that even were I an attorney, I would hesitate to try to deal with such a complex and difficult issue as presented here today.

Mr. WAXMAN. That makes you an attorney.

Mr. DESSART. It is a very interesting question.

Mr. DANIELS. I think some of the advertisers and agencies that are producing the commercials have a very serious concern about what they are saying and what they are persuading you to do and what the implications of those messages are. I've been told, since I just returned, that one advertiser backed off of any reference to AIDS because of the very point that you are making.

It is a very difficult question. It is one they are going to have to deal with now and at some point individual broadcasters that have already carried condom advertising must deal with.

Mr. SCHNEIDER. Mr. Congressman, I am an attorney but I don't feel qualified to answer that. I will leave that to more competent attorneys in our company.

Mr. DANNEMEYER. Mr. Chairman, I would like to make an observation. I commend you for holding this hearing. There are steps that can be taken by public health authorities in order to reduce this epidemic that is facing the American people today. I am one of

those who have introduced legislation on this subject. I hope you will schedule hearings.

We have witnesses that want to come and testify and say to the American people that there are other steps besides advertising condoms that the public health authorities and the United States Government can take in order to reduce the incidence of the transmissibility of this fatal disease, such as making it reportable then we could deal routinely with the AIDS virus as we do with any other sexually communicable disease. Making it a crime for a person who knows they have the virus to voluntarily transfer bodily fluids; requiring or suggesting to States of the union that before you can get married, you have a blood test to show you don't have the virus; telling the blood banks of America that it is time we set up directed donations for people who want to donate blood, because frankly the blood supply of this country is not as good as we would like to have it.

There are certain categories of people that should be tested for the presence of the virus; prostitutes; those that are long-term prisoners in prison populations. We should deal specifically with the question of whether or not children with AIDS should be in public school in terms of a recommendation and the health consequences that come to those students who attend classrooms with children with AIDS.

We should say to health care workers who have AIDS, if you can believe this today, it is still a policy, so far as I have been able to determine of the Public Health Department of the United States Government, that a person with AIDS can work in the health care professions of this country. That is absolutely ridiculous. A person with AIDS is a repository for many other communicable diseases that are opportunistic in nature that come to that person because their defense system has been compromised. Health care workers should be permitted to wear gowns, masks and gloves when they treat AIDS patients.

We still have bath houses operating in this country because we have some public health officials in major cities of America who don't have the guts to shut them down.

We should make it very clear it is a crime for persons to donate blood, to make clear that we want to respect the integrity of our blood supply.

Right here in Washington, DC, we have a District of Columbia that has said to the insurance industry, you can't require as a condition of getting a policy of insurance, that you have your blood tested by any test for AIDS. In California, we proscribe testing for the AIDS virus. We should say flat out as a policy that tests should be available to insurance companies to be routinely used.

These are some of the public health responses that in my judgment make sense. We must treat this issue as a public health issue, not as a civil rights issue. The whole scope of this hearing today, commendable as though it may be, suggesting that we can say to the American people, if you use a condom, you are free from AIDS, is ridiculous. We should be saying that up front, just to give the matter the perspective I think it deserves.

Mr. WAXMAN. Will the gentleman yield to me?

Mr. DANNEMEYER. I would be happy to yield.

Mr. WAXMAN. If you have some other suggestions for stopping the spread of this disease, we ought to evaluate those suggestions. But to dismiss the one idea about which all the public health experts are unanimous in their view—that is that the risk of AIDS can be greatly lessened by the use of condoms should people be engaging in sexual intercourse—to dismiss that idea is to dismiss one good idea because you think other ideas aren't being considered.

Mr. DANNEMEYER. Mr. Chairman, you don't understand me, sir. I'm not suggesting that the use of condoms is not a good tool. I am just suggesting that for the sake of perspective, given what we are doing here—this is a hearing of the Congress of the United States setting public policy. I would have preferred frankly that we set the first hearing of this Congress on the subject of the steps that are needed to curtail the spread of this disease, not steps designed to ensure that we can continue permissive lifestyle that we have fostered in America. That's what I'm saying.

Mr. WAXMAN. If the gentleman will permit, we have been available to hold any hearings that the Reagan administration and their public health officials have requested of us and to take any steps they have deemed advisable and to be ready to pass legislation that they think would be helpful to combat the AIDS epidemic.

If you have suggestions, I am sure they would be happy to review them and we will look at them as well. If they have merit, we want to implement them.

It is our task to stop this epidemic from killing more people.

Mr. DANNEMEYER. Mr. Chairman, you know full well that this member has introduced certain bills on this subject and in writing, I have asked you to hold hearings and I haven't had a response yet. I hope sooner rather than later, you will give me the courtesy of a response as to when you are going to set hearings on those pieces of legislation that I have introduced.

Mr. WAXMAN. Mr. Dannemeyer, the answer has to be that I am going to say no. We are not going to hold a hearing to have Lyndon LaRouche come in and give us his views. We want to hear from responsible public health officials.

Mr. Tauke.

Mr. TAUKE. I almost hesitate to jump into the fray.

I was going to observe before either of the gentlemen from California commented, that it seemed to me in view of the testimony that we heard from the first two witnesses, that it's rather appalling that our response to this national epidemic is to have a discussion about whether or not to advertise condoms on TV. But apparently, that's what we're doing this morning.

And I guess the second observation I would make is that it occurs to me that this industry has tried to ride various horses into the racetrack, I guess, of TV advertising, and they haven't been successful riding other horses, so they've found one that apparently is more appealing.

And I want to commend each of you for your testimony, but I have to tell you frankly, I was disappointed in your response to the advertisements, because I think the advertisements highlighted just some of the problems that you have when you have the people giving the message on the AIDS issue, be people who have a different motivation from public health.

The first advertisement ended with the tag line, "Use it in good health." The implication surely is that the way in which you stop AIDS is to use condoms, and it implies that condoms mean safe sex, when we know that condoms do not guarantee safe sex, and most of the studies that have been done relating to the use of condoms have related to vaginal intercourse, not other kinds of intercourse, and there is some evidence to suggest that condoms mean less safe sex when used for anal rather than vaginal intercourse.

And I guess that it would seem to me that somebody should have said on the panel, "We've got a problem with the message that is being delivered by this advertisement." It is not the public health message that has been articulated by the previous two speakers.

The second one says, "I'll do a lot for love," which—that's the tag line on that commercial. I'm not sure exactly what the implication is, but it seems to me that it advocates sex as a necessary part of love under somewhat undefined conditions of age or other undefined conditions. And I guess it suggests that—"I'll do a lot for love" seems to suggest that I'll take the risk of getting AIDS in order to ensure that I have this relationship.

I'm not sure that's the message we want to send either. And so I guess it seems to me, which I've already articulated in this hearing, that you have a significant problem when you have a company buying advertising to increase the use of its product, and then you're trying to hide behind a public health message, which should be—should have a somewhat different twist to it, it seems to me.

Let me just ask a couple of questions after that little commentary.

The way your system works, if you run an advertisement on the network and a local affiliate decides not to air that advertisement, it may take some technical step to prevent that advertisement from being aired?

Mr. DANIELS. I'm sorry. Is the question, can they take?

Mr. TAUKE. If ABC runs a commercial on your network, can KDUB-TV in Dubuque, Iowa excise it?

Mr. SCHNEIDER. The answer is, "yes, but." Ordinarily a station is required, when it accepts the program, to accept the program along with the commercials that are presented within that program. However, there has been occasion when—and this was in the early days of feminine hygiene products—when certain stations indicated that they did not find that they wished to accept, because of their own interpretation of those commercials, that they were permitted to cover that particular advertisement or commercial with a public service announcement. They could not sell the time, but they could do—they could cover that.

I'd like to comment about the two things you said, too.

Mr. TAUKE. Yes.

Mr. SCHNEIDER. In the first part—the first commercial, I think I said that I agreed on the questions of taste. I did not address the question of efficacy. And I think the question you raise is whether that first commercial raises a question of efficacy or not in terms of their copy line, and that's a question that I think we would have to deal with.

Mr. TAUKE. If the effort is education for public health——

Mr. SCHNEIDER. Correct.

Mr. TAUKE. Which, of course, is not the effort of the condom companies, but if the effort is education for public health, it doesn't seem to me that that's the proper message. But go ahead.

Mr. SCHNEIDER. Right. But, you know, that is certainly a question in terms of the question of taste.

The second one, I quite agree with you. I think the last line is something that I would find questionable.

Mr. TAUKE. Well, let me just close by saying that I would not want you to construe my comments to suggest that I think everything is well. I think that there is a strong necessity for the networks to use the public service announcements that are apparently now only recently available and to get those on the air. I trust they're good; I haven't seen them, but to get those on the air and get them on in times other than the times when your viewership is way down, but to get them on in prime time.

But I also hope that you don't allow the need for good public health to permit you to put on the air advertisements that, in my view, don't achieve the goal of public health education.

Mr. WAXMAN. If I might ask the three of you, is there any policy that would prevent you from selling prime time television to the Public Health Service of the U.S. Government?

Mr. DANIELS. No, there is not. I'm not sure where Dr. Osborn got that idea, but it's simply not true.

Mr. WAXMAN. I assume the misunderstanding was that you don't run public service announcements for free during prime time, but you would sell it?

Mr. DANIELS. Generally speaking, we do sell time. That's our source of revenue. But we do, in fact, run—we have 121 public service organizations for which we're running announcements, and some of those do go in prime time.

Mr. WAXMAN. What are you going to do if the Government of the United States, the Public Health Service, wants to buy an ad during the time when most viewers will be watching, but you fear that some people around the country may be offended by it? What will you do?

Mr. DANIELS. I think my original statements speak for NBC. We would have to put that—that's in the category of condom advertising, or presumably it would relate to that, and that's part of what we're evaluating right now and considering in the light of what is, in fact, an experiment amongst some television stations and publications that are publishing and broadcasting condom advertising.

Mr. WAXMAN. Now just to clarify another point. Each of you stated on the record that your local affiliates are free to accept condom advertising, should they choose to.

Is that true of the owned and operated network stations?

Mr. DANIELS. In the case of NBC, it is not. We have a company policy. We'll be dealing with the owned stations as well as the network policy.

Mr. WAXMAN. So that owned stations would not be permitted to take condom advertising?

Mr. DANIELS. At the moment, that's correct.

Mr. WAXMAN. In what locations are your owned stations?

Mr. DANIELS. New York, Los Angeles, Cleveland, Chicago, and Washington.

Mr. WAXMAN. That sounds like pretty largely populated areas that wouldn't have the benefit of advertising even if their local stations that were part of your network thought that they could handle ads like the ones we've seen.

So you would prevent your stations in Los Angeles, Washington, DC, New York, Chicago, and Cleveland from running an ad, even if they thought their local people would be accepting of it?

Mr. DANIELS. As the policy stands.

Mr. WAXMAN. How about your network, Mr. Dessart?

Mr. DESSART. Our affiliates are free to set their own policy, as was explained. Our own stations at the moment are trying to come to grips with this question. They're grappling with it and grappling with their community attitudes, and the question is very much alive at the moment.

I would like, sir——

Mr. WAXMAN. What stations—what are the localities that are grappling with whether their people can take these ads? What locations are they?

Mr. DESSART. New York and Chicago and Los Angeles and Philadelphia.

Let me say, sir, that with respect to the prime time PSA question——

Mr. WAXMAN. Yes.

Mr. DESSART. We have a fixed position every evening in prime time, in addition to those other positions which become available. We have already run that new series of PSAs that we have produced in that prime time position and expect to do so very frequently.

Mr. WAXMAN. So you have produced a PSA that you will run on prime time?

Mr. DESSART. Yes, sir.

Mr. WAXMAN. I see. Mr. Schneider.

Mr. SCHNEIDER. The Cap Cities/ABC stations are free to accept condom advertising in their markets as they see fit, after a review of copy which we do with them.

Mr. WAXMAN. Including the owned and operated stations?

Mr. SCHNEIDER. All the owned and operated stations; yes, sir.

Mr. WAXMAN. Thank you very much.

Well, I can only say to the three of you that certainly one of the purposes of this hearing was to get you to rethink your position and to look at this problem in the context that we're looking at it today, the enormous public health tragedy that is taking place before our eyes at this moment in time.

And I must tell you that as I listen to the debate about whether those two ads were offensive or not or whether one message or another ought to be sent out, I am concerned that time is being wasted. Right now, we're not sending out any message that's effective enough to stop this epidemic from spreading. Public information has to be our major way to stop the AIDS epidemic from continuing on.

Thank you. Are you ready to move on?

Mr. DANNEMEYER. I just want to say, Mr. Chairman, that you may intend to call Lyndon LaRouche; I don't. The bills that I have introduced, the witness that I want to bring before this panel, are

reputable public health officials and persons working in private medicine in America who believe the public health response that we have taken up until now to deal with this epidemic is not the correct one.

Mr. WAXMAN. Well, then we will have to review that issue.

Thank you very much for being with us.

[The following letter was submitted for the record:]

National Broadcasting
Company, Inc

30 Rockefeller Plaza
New York, NY 10112
212 664-2135

Ralph Daniels
Vice President
Broadcast Standards

NBC

February 20, 1987

The Honorable Henry A. Waxman
Chairman
Subcommittee on Health
and the Environment
U.S. House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

Since my testimony before the Subcommittee on February 10, 1987, NBC has amended its policy on condom advertising as it impacts on NBC-owned stations. Each station's local management may now elect to accept such advertising. This modification in policy is a result of NBC's continuing review of evolving circumstances which I referred to in my testimony.

WNBC-TV, the NBC-owned station in New York City, on February 19, 1987, announced its intentions to accept condom advertising under certain conditions. I attach a copy of the station's press release for your information. We would appreciate your including this letter (and enclosure) as a supplement to the record of my testimony at the Subcommittee's hearing on condom advertising.

Respectfully yours,

Ralph Daniels

Ralph Daniels
V.P. Broadcast Standards

RD:alh

Enclosure

Press Release

WNBC-TV New York

CONTACT: Lissa Eichenberger (212)664-4208

WNBC-TV TO EXPAND EFFORTS TO INFORM PUBLIC ABOUT AIDS THROUGH FOUR PHASE PROGRAM INCLUDING THE ACCEPTANCE OF CONDOM ADVERTISING

WNBC-TV will accept condom advertising for the purpose of educating the public on reducing the risk of AIDS effective immediately, it was announced today by Bud Carey, WNBC-TV Vice President and General Manager. In addition, Carey outlined a four-phase educational effort to inform the public on the epidemic parameters of the spread of the fatal disease.

The four phases are:

1. Continued coverage of the AIDS issue in news and public affairs programs.
2. A series of editorials discussing the problems and issues surrounding AIDS.
3. The production of and acceptance from qualified public organizations of public service announcements, including those which refer to the use of condoms for the purpose of reducing the risk of AIDS. Such public service announcements must comply with WNBC-TV's guidelines.
4. The acceptance of condom advertising. Any such advertising must be solely directed to the use of condoms for the purpose of reducing the risk of AIDS and not for either contraceptive purposes or for the purpose

MORE...

of encouraging sexual activity. No such announcements may air prior to 11:00PM.

All such advertising will be reviewed in accordance with WNBC-TV's standards of taste, taking into account composition of the audience, and must comply with other applicable provisions of Channel 4's Advertising Guidelines, including documentation of claims.

Carey said: "Statistics from New York City's Health Department show that the number of AIDS cases in New York represents over 30% of the total in the nation. That is a staggering figure. Because television is a medium with the power to educate and inform, and in response to this growing health emergency in our viewing area, we feel it is incumbent upon us to expand our efforts on this subject."

Carey continued: "We realize that members of our audience may not readily accept this action, but we feel a responsibility to support the efforts of public health officials in the education of our viewers."

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Mr. WAXMAN. Two witnesses are appearing on the final panel for today's hearing. Dr. Theresa Crenshaw is both Director of the Crenshaw Clinic in San Diego, California, and President of the American Association of Sex Educators, Counselors and Therapists.

Dr. Michael J. Rosenberg is Executive Director of the American Social Health Association.

I want to thank both of you for appearing before us today. We have your prepared statements, I believe, and will make them part of the record in full. We would like to ask you to take 5 minutes to summarize your presentations to us.

Dr. Crenshaw, could you be sure that the mike is on. Push the buttom forward.

STATEMENTS OF THERESA L. CRENSHAW, PRESIDENT, AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS, AND THERAPISTS; AND MICHAEL J. ROSENBERG, EXECUTIVE DIRECTOR, AMERICAN SOCIAL HEALTH ASSOCIATION

Ms. CRENSHAW. I would like to add for a point of reference that I am a physician, and my specialty in medicine is human sexuality.

If I told you that you had a 10 percent chance or greater of dying when you cross the street after you leave this hearing, I wonder if you would do it. Or if I was speaking to you here as a credible expert, I wonder if you would find me so, if I told you to take a gun with one loaded bullet and pull the trigger.

I am concerned about the thinking that we have on these condoms in the AIDS epidemic, and I am concerned about the thinking we have about the epidemic in general. I am going to demonstrate to you through common sense, as well as through research, that condoms have probably a significantly greater than 10 percent chance of failure, and I am going to ask you to listen with an open mind and with your denial systems disengaged to see if you can't weigh what I share with you objectively.

We have our wishful thinking and our guesswork, but we have no reliable figures on the safety of condoms for preventing AIDS. Preliminary studies demonstrate that they delay infection, but do not prevent it. Existing studies are not large enough nor have they continued long enough to be conclusive. Five years would be the minimum, and we are operating on the basis of 1 to 3 years so far.

While they are not foolproof, condoms are a valuable resource in the battle against AIDS. Tasteful advertising on television and in print is appropriate, in my opinion. Networks that already advertise tampons, douches, and deodorants should have no difficulty including condoms as sponsors. However, truth in advertising requires that the 10 percent failure rate for pregnancy per woman-year of condoms in practice be included with each advertisement, especially since the consequences can be fatal.

Advertising should not imply that condoms are the solution to the AIDS epidemic. To do so would be dangerously misleading, since we do not yet know how great the failure rate will turn out to be for AIDS. I suggest condom advertisers be responsible to the public by stating something to the effect that condoms do not guarantee safety; the best protection against AIDS is celibacy or monogamy with a trustworthy partner who is not already infected. If you

are not 100 percent certain that your partner has been trustworthy for the last 5 to 7 years, use condoms anyway. If you choose to have unsafe sex, protect yourself with a condom in conjunction with a spermicide.

This cautionary message will not discourage the use of condoms, because they have some value. However, it will encourage many individuals to become even more careful by developing exclusive relationships with uninfected partners. The Surgeon General might say something like, "Condoms could be hazardous to your health, but use them if you're not going to use good judgment."

Sex education in schools could be the first major step in arresting the progression of AIDS. Prevention through education is the key. It requires no miracles, no research. A massive public education campaign is long overdue and can be effective; however, if the wrong information is given—and I fear it is being given—the effort will fail. It will cause death rather than prevent it.

The responsibility is a grave one. Any safe sexual practices recommended must be genuinely safe. Safe sex practices centering around the use of condoms are not as safe as the public has been led to believe. While in most laboratory experiments, they do not pass sperm, herpes, or the AIDS virus, in practice they have a 10 percent failure rate for pregnancy per woman-year.

A woman—now think about this—a woman is able to get pregnant only 3 to 5 days a month. She is susceptible to AIDS 365 days a year. Sperm are 500 times larger than a virus. Often overlooked is the fact that sexual arousal is much like alcohol intoxication; the first thing to go is your judgment. Good intentions to use condoms may disappear in the heat of passion. Teenagers are notorious for carrying condoms in their wallets and leaving them there. Condoms are no protection in your pocket.

Taking these factors into consideration, common sense suggests that the failure rate for the AIDS virus will be much higher than 10 percent.

Being selective is not enough. When you have sex with someone, you are having sex with everyone that they have had sex with during the past 5 to 7 years. AIDS, like taxes, is retroactive. You may be able to judge an individual's character, but you cannot evaluate all the others. It is impossible to be selective.

The only safe sex is celibacy or masturbation. Next best is monogamy with a trustworthy partner who is not already infected. Unless these are the recommendations taught in school and to society at large, the education campaign will simply perpetuate myth and misinformation, postponing disease but not preventing it.

Saying that the use of condoms is safe sex is, in fact, playing Russian roulette. A lot of people will die in this dangerous game. Cases have already been reported of women who developed AIDS while depending on condoms for protection. Two women out of 12—and these figures are now erroneously low—who continued to have sex with their partners who have AIDS, while depending on condoms for protection, have become infected with the AIDS virus. How much more evidence do we require?

Given the presumed safety of condoms, this is, quote, "a very disturbing finding," according to Margaret Fischl, the Study Director. The spread of the AIDS virus within our population demonstrates

that our efforts to date have not been sufficient. AIDS is not killing us; behavior is. Survival or extinction is our choice. The AIDS virus will win this game of Russian roulette if we don't act more responsibly now.

Do we have the discipline and the courage to make the right choices, or will we continue to mislead ourselves and others until it is too late?

This epidemic can be beaten, but only by eliminating the risk. Reducing the risk is important but not enough. Gambling with our lives, hiding from the truth, is not the solution, in my opinion. The AIDS virus will not get you without your cooperation.

There is a solution, but it can no longer be half-measures. For the sake of health, casual sex and multiple partners must be abandoned. So-called safe sex practices are not enough. Celibacy, masturbation, or monogamy in a trustworthy relationship will stop the spread of this disease.

If today everyone were magically frozen with their present sexual partner, we would not have very many cases of AIDS tomorrow. This is not realistic, but we can aim for quality relationships instead of quantity. Most people erroneously believe that you can't significantly change someone's sexual behavior. These opinions come from individuals not expert in the field of human sexuality, and I am here to tell you that we can change human behavior. And if exclusive relationships are the requirement of our health and well-being, if you ask people to do this, you will persuade the majority. Granted not all, but if you don't try, you won't have a chance of having that effect.

Sexual behavior can change, but not unless we expect it and recommend it. And I disagree with individuals who are expert in other disciplines, who are making pronouncements about the complexities of human sexual behavior that they have not studied and do not fully comprehend.

Within a committed relationship, the quality and quantity of sex can be unrestricted. Sex need not be limited, dull, boring, or handicapped in any respect whatsoever. Life can still be fun and full of romance. However, outside that relationship, sex of any kind can be fatal. The choice is ours.

Condoms in combination with spermicides are a valuable resource in our fight against AIDS, but condom sense is not a substitute for common sense and needs to be our second line of defense, not our first.

Thank you.

[Testimony resumes on p. 86.]

[The prepared statement of Ms. Crenshaw follows:]

Condom Advertising

Testimony of Theresa L. Crenshaw, M.D.
February 10, 1987

We have no reliable figures on the safety of condoms for preventing AIDS. Preliminary studies demonstrate that they delay infection but do not prevent it. Existing studies are not large enough nor have they continued long enough to be conclusive. (Five years would be the minimum.)

While they are not foolproof, condoms are a valuable resource in the battle against AIDS. Tasteful advertising on television and in print is appropriate. Networks that already advertize tampons, douches and deodorants should have no difficulty including condoms as sponsors.

However, truth in advertising requires that the 10% failure rate (for pregnancy, per woman year) of condoms in practice be included with each advertisement, especially since the consequences can be fatal.

Advertising should not imply that condoms are the solution to the AIDS epidemic. To do so would be dangerously misleading since we do not yet know how great the failure rate will turn out to be for AIDS. I suggest condom advertisers be responsible to the public by stating something to the effect that:.."Condoms do not guarantee safety. The best protection against AIDS is celibacy or monogamy with a trustworthy partner who is not already infected. If you are not 100% certain that your partner has been trustworthy for the last five to seven years, use condoms anyway. If you choose to have unsafe sex, protect yourself with a condom plus a spermicide."

This cautionary message will not discourage the use of condoms, because they have some value. However, it will encourage many individuals to become even more careful by developing exclusive relationships with uninfected partners.

CONDOMS ARE NOT ENOUGH

Sex education in schools could be the first major step in arresting the progression of AIDS. Prevention through education is the key. It requires no miracles, no research. A massive public education campaign is long overdue, and can be effective.

However, if the wrong information is given, the effort will fail. It will cause death rather than prevent it. The responsibility is a grave one.

Any safe sexual practices recommended must be genuinely safe. "Safe Sex" practices centering around the use of condoms are not as safe as the public has been led to believe. While in most laboratory experiments, they do not pass sperm, herpes or the AIDS virus, in practice, they have a 10% failure rate for pregnancy (per woman year). A woman is able to get pragnant only three to five days a month. She is susceptible to AIDS 365 days a year. Sperm are 500 times larger than a virus. Often overlooked is the fact that sexual arousal is much like alcohol intoxication. The first thing to go is your judgement. Good intentions to use condoms may disappear in the heat of passion. Teenagers are notorous for carrying condoms in their wallet and leaving them there. Condoms are no protection in your pocket. Taking these factors into consideration, common sense suggests that the failure rate for the AIDS virus will be much higher than 10%.

Being selective is not enough: When you have sex with someone, you are having sex with everyone that they have had sex with during the past five to seven years. AIDS, like taxes, is retroactive. You may be able to judge an individual's character, but you cannnot evaluate all the others. It is impossible to be selective. The only safe sex is celibacy, or masturbation. Next best, is monogamy with a trustworthy partner who is not already infected. Unless these recommendations are the one taught in school and to society at large, the education campaign will simply pertetuate myth and misinformation - postponing disease but not preventing it.

Saying that use of condoms is "safe sex" is in fact playing Russian Roulette. A lot of people will die in this dangerous game. Cases have already been reported of women who developed AIDS while depending on condoms for protection. Two women out of 12 who continued to have sex with their partners who have AIDS, while depending on condoms for protection, have become infected with the AIDS virus. Given the presumed safety of condoms, this is a "very disturbing finding" according to Dr. Margaret Fischl, the study director.

The spread of the AIDS virus within our population demonstrates that our efforts to date have not been sufficient. AIDS is not killing us, behavior is. Survival or extinction is our choice. The AIDS virus will win the game of Russian Roulette if we don't act more responsibly now. Do we have the discipline and courage

to make the right choices or will we continue to mislead ourselves and others until it is too late?

This epidemic can be beaten, but only by eliminating the risk. Reducing the risk is important but not enough. Gambling with our lives, hiding from the truth, is not the solution.

The AIDS virus will not get you without your cooperation. There is a solution, but it can no longer be half measures. For the sake of health, casual sex and multimple partners must be abandoned. So called "safe sex" pactices, celibacy, masturbation or monogamy in a trustworthy relationship will stop the spread of this disease. If today, everyone were magically frozen with their present sexual partner, we would not have verymany cases of AIDS tomorrow This is not realistic, but we can aim for quality relationships instead of quantity. Most pepole erroneously believe tha you can't significantly change someones sexual behavior. These opinions come from individuals not expert in the field of human sexuality Sexual behavior can change, but not unless we expect it and recommend it.

The AIDS peidemic is forcing us to develop qualities that are not undesirable: trustworthiness,inimacy, commitment, compassion. The quality of monogamy will improve. Patients are already coming to my clinic for marriage an sexual couseling who would have simply gotten a divorce a few years ago. they say "It's a terrible time to be single. I don't like him/her much either. Please help us improve our relationship so that we will want to stay together." Married men and women wo used to supplement their relationships sexually on the outside arecoming to therapy in an effort to improve their relationship enough so that they won't want to stray. Singles are comign to me because they are afraid of getting AIDS and too embarrassed to bring the subject up on a date. They need to learn an entirely new set of social skills which can be accomplished relatively easily with the right guidance.

Within a committed relationship, the quality and quantity of sex can be unrestricted. Sex need ot be limited, dull, boring or handicapped in any respect whatsoever. Life can still be fun and full of romance. However, outside that relationship, sex of any kind can be fatal. The choice is ours, will it be Russion Routlette or survival. Condoms in combination with spermicides are a valuable resource in our fight against AIDS. But condom sense is not a substitute for common sense.

Theresa L. Crenshaw, M.D.
President of AASECT
Chair AIDS Task Force-AASECT

Survival or Extinction:
The Choice Is Ours
by
Theresa L. Crenshaw, M.D.

The AIDS virus is winning. Today, there are ten times more cases of AIDS in heterosexuals than we had in the homosexual community 5 years ago. In our major cities, 50% to 70% of homosexuals are already infected with the AIDS virus. Heterosexuals seem to be repeating their history.

We could lose one quarter of the worlds population before we gain control of this epidemic, even if we act swiftly now. If not, if may be more. The United States leads the industrialized world in numbers of AIDS cases.

We have 30,000 cases of AIDS, 300,000 ases of ARC and 3,000,000 asymptomatic carriers in the United States alone. Dr. Halfdan Mahler, leader of the World Health Organization, estimates that there are 10,000,000 people infected world-wide and that 100,000,000 cold be infected with the AIDS virus by 1991. If the spread of AIDS continues at the same rate, in 1996, there could be one billion people infected; 5 years later, hypothetically 10 billion; however, the population of the world is only 5 billion. Could we be facing the threat of extinction during our lifetme? Even before our children are grown?

To prevent this eventuality, we must change our approach to the management of this pandemic dramatically. We have not done a good job to date. We are not now doing what needs to bedone. The number of infected people contradicts anyone who suggests otherwise. We have been illogical and ineffective. When 90% of those infected and contagious to others don't know it, how can we hope to stop the spread of this disease? Even though we have no cure, our solution depends upon prevention. Each indivisual must find the courage to be tested; then exercise the discipline to remain negative or to avoid spreading the disease to others if positive.

What have we done wrong?

1. We have discouraged testing of the general population.

2. We have not made all forms of infection (ARC,confirmed antibody positive status) with the virus reportable.

3. We have not revealed all the facts for far of engendering panic - the result is a misinformed public who believes, among other things, that this infection is hard to get, that heterosexuals are not at high risk and that the AIDS antibody test is unreliable.

4. Authorities have repeatedly made absolute statements abot AIDS based on the faulty reasoning that "there has been no case yet,". Many of these statements have later been proved untrue. "There has never been a case of heterosexual transision. . . . Males can't get it from females. . . . There has been no case of AIDS due to needle stick. . . ." These are just a few examples of statements that have had to be reversed at a later date. Yet the majority of experts are still using the "no case yet" thory to make new absolute statements reagardng saliva, casual transmission and insects. "No case yet" reasoning does not work in an epidemic that can take 5-10 years to manifest itself.

5. We have poured funds into treatment and only recently directed funds for prevention through education.

6. We have protected civil rights at the expense of health, allowing people to infect others knowingly and unknowingly.

7. We have dangerously underestimated this epidemic, and continue to do so, accusing those who express concern of being alarmists.

8. We have passed laws taht interfere with the public health management of this disease and with the medical treatment of infected individuals. (i.e., in some States (California, New York) a physician is not allowed to

What we must do right:

1. Make all forms of infection reportable to the public health department.

2. Encourage voluntary testing for the general public, including children.

3. Tell the public the whole truth. The present message "Calm down, don't panic, but change your sexual behavior" will not work psycodynamically, motivate sexual behavior change. One must alarm and concern people enough to motivate change, then calm them down with an action plan that demonstrates how to prevent infection.

4. Stop making absolute statements based on the "no case yet theory." Instead state that the data is inconclusive or preliminary, or promising, but will require time and, additional studies to confirm.

5. Fund sex educational prevention programs and testing programs.

6. Modify civil rights issues as necessary for health and survival. Don't let the exercise of the rights of someone who is infected cause someone else to become infected.

7. Stop underestimating this disease. Stop trying to see how much sex or what sexual behaviors one can get away with without becoming infected. Stop playing Russian roulette. This is no time to be careless.

8. Modify existing laws to conform with good medical and ethical practices.

9. Recognize that sexual behavior can change if the motivation is sufficient and if public leaders expect and recommend it. Death is a powerful motivator.

10. Don't delude ourselves with condoms, but do use them. Recommend exclusivity in relationships and condoms and spermicides unless one can be 100% certain one's partner is monogamous and uninfected (which is difficult).

In conclusion, our society is in grave danger, not from AIDS, but from the experts who have consistently misread this epidemic, disregarded the evidence of Africa, been unwilling to apply traditionally epidemeological methods (such as routine testing and contact tracing); from gay leaders who have resisted any measures that might limit or inhibit sexual freedoms; from the conservative right who have fought AIDS education in schools and on television; and from ourselves, who have been unwilling to change our sexual practices radically enough or rapidly enough.

Time has run out for millions of people, and the clock is still ticking, marking victims every minute as we deliberate.

We need to mobilize all of our resources, stop arguing and work together: gays, conservatives, liberals, Democrats, Republicans.

Celibacy, monogamy, condoms, spermicide, education, contact tracting, testing -- are some of our resources. We must utilize them all.

We have a common goal: stop AIDS. We must work together as a nation toward this end, and stop drawing battle lines between philosophies. This epidemic was preventable, it is still manageble, but just barely and only if we act effectively now.

Condoms may not prevent AIDS transfer, expert says

UNITED PRESS INTERNATIONAL

LOS ANGELES — The use of condoms does not eliminate the possibility of getting AIDS through sexual activity, a medical researcher says.

In an article that appeared in the British Medical Journal last week, Dr. Bruce Voeller of Los Angeles said the condom has no proven value in preventing the transmission of sexually transmitted viral diseases — including acquired immune deficiency syndrome.

"This is the first time anyone in scientific literature has spoken out on the limitations of condom usage in preventing the AIDS virus," said Voeller, who is a co-author of the article.

"The Consumers Union reported laboratory testing of American brands of rubber and skin condoms and found significant leakage in some brands," the report said. "The Consumers Union also reported variable degrees of deterioration in a third of the 21 rubber brands tested."

"Health institutions have been telling people, 'for safe sex, use a condom.' Our point is that while the condom gives a measure of protection there is no research to show the exact protection," Voeller said in a recent interview.

Voeller, president of the Mariposa Foundation in Los Angeles, a medical research institution, said sperm are many times larger than any known virus, including the AIDS virus. He said if the accepted failure rate for condoms when used for the prevention of pregnancy is 10 percent, the failure rate for the prevention of AIDS would be considerably higher.

condom failure

Voeller said adequate brand testing studies of condoms should be conducted.

"If your life depends on how safe a particular brand of condom is, wouldn't you want to know its effectiveness?" he said.

Voeller also said instruction in correct usage of condoms is important.

"Even though we believe that condoms afford a substantial degree of protection and their use should be encouraged, that encouragement should be tempered with cautionary warnings discouraging increased sexual activity," the report said.

The co-author of the study was Dr. Malcolm Potts, director of Family Health International in Research Triangle Park, N.C.

San Francisco Examiner 11-7-85

S.F. has 60 new AIDS cases, 43 deaths

UNITED PRESS INTERNATIONAL

Sixty new cases of AIDS were diagnosed in San Francisco in October and there were 43 AIDS-related deaths, the city Department of Health reported.

A spokesman said yesterday the number of deaths from acquired immune deficiency syndrome reported during the month was 10 more than in September, although the number of new cases reported declined slightly from September's figure of 62.

Since July 1, 1981, San Francisco has recorded 1,499 cases of AIDS and 784 AIDS-related deaths, roughly 1 percent of The City's population. The totals for 1985 are 629 new cases and 382 deaths.

Table 2. Percentage distribution of women discontinued IUD use between January and the NSFG interview date, by exposure to the risk of unintended pregnancy and contraceptive use at time of survey

Status	All women	Women at risk
Not at risk	37	na
Pregnant, postpartum, seeking pregnancy	21	na
Noncontraceptively sterile	10	na
Not sexually active	5	na
At risk	63	100
Using a method	54	86
Sterilization	28	45
Pill	14	22
Condom	3	4
Diaphragm/spermicides	9	14
Periodic abstinence	0	0
Other	*	*
Using no method	9	15
Total	100	100

*Less than 0.5 percent.
Notes: na = not applicable.

In the following section, we attempt to quantify the effects that changes in method use might have on the risk of pregnancy among current IUD users. The analysis takes as its starting points the patterns of method use found among women who have already stopped using the IUD, the fact that only 44 percent of current IUD users are candidates for oral contraceptives and the fact that 35 percent of IUD users say that they want no more children.

Table 2 shows the distribution of women who discontinued IUD use between January 1980 and the NSFG interview date (late 1982 or early 1983), according to their method use at the time of survey. At that time, 37 percent were no longer at risk of unintended pregnancy because they were pregnant, postpartum or seeking pregnancy, because they had become noncontraceptively sterile, or because they were not sexually active. The other 63 percent probably offer the best indication of what current IUD users forced to discontinue their method might do, since it is fecund women at risk of pregnancy—not women who are pregnant, seeking pregnancy or postpartum—who would normally be using this method.

Among the women still at risk, 45 percent had chosen sterilization of themselves or their partners—an unsurprising finding, given the large proportion of IUD users who say that they want no more children. The next largest contingent of former IUD users, 22 percent, had switched to the pill, the most effective reversible contraceptive. Fourteen percent had adopted the diaphragm or spermicides, and four percent had adopted the condom; but 15 percent were using no method.

Table 3. Percentage of married women who experience a pregnancy within the first year of contraceptive use, by method used

Method	%
Sterilization	0.4
Pill	2.1
IUD	4.2
Condom	9.8
Diaphragm/spermicides	16.3
Periodic abstinence	21.2
Other	10.6
None	66.0

Note: Except for sterilization, rates are based on women aged 20–29 who had family incomes of $10,000–$15,000.

Sources: Failure rate for sterilization—H. W. Ory, J. D. Forrest and R. Lincoln, *Making Choices—Evaluating the Health Risks and Benefits of Birth Control Methods*, The Alan Guttmacher Institute, New York, 1983, Pp. 1. Rates for other methods—see references 21 shown here are averages of the rates for wo... seeking to prevent pregnancy and the rates for those seeking to delay pregnancy.

The Risks of Changing Method

To the extent that women switch from the IUD to an even more effective method, they will face a lowered risk of unintended pregnancy, whereas they will face an increased risk if they choose a less-effective method or no method at all. We use the pregnancy rates shown in Table 3 to estimate the effect of movement from the IUD to other methods. For all methods except sterilization, these rates are based on women aged 20–29 who have annual family incomes of $10,000–$15,000, and represent the averages of the rates among women seeking to delay and those among women seeking to prevent a future birth.[21] Use of these criteria, we believe, reflects somewhat more closely the actual characteristics of current IUD users (the largest proportion of whom are in the 25–29 age-group) than either the failure rates of all current users,[18] or the rates standardized to the age, income and pregnancy-intention distribution of all women using a method,[22] we have based the rates for the other methods on the same criteria, in order to use failure rates of women comparable to those using the IUD.

The pregnancy rates shown in the table are first-year failure rates per 100 woman-years of use. However, failure rates for the IUD decline with increasing duration of use,[24] and four-fifths of IUD users have used the method for more than one year.[25] In changing methods, moreover, IUD users would be starting the first year of use of a new contraceptive. Thus, the pregnancy rate used here for the IUD is probably somewhat high relative to the other rates. As for the one-year pregnancy rate associated with use of no method, the 63 percent shown in the table represents an educated guess, the figure commonly used for sexually active nonusers —56 percent[26]—seems to us too high, because of the relatively older age (though proven fecundity) of most IUD users.

To assess the effects of IUD discontinuation on the level of unintended pregnancy risk, we compare three possible scenarios of subsequent contraceptive practice by IUD users with a baseline estimate of the 4.2 percent annual pregnancy rate that could be expected if IUD availability were to stay the same. The results are shown in Table 4.

Scenario 1 assumes that current users move to the most effective methods possible—that is, all those who want no more children become sterilized (55 percent), those who want more children and can use the pill do so (30 percent—not shown), and the remaining 15 percent rely on their partners' use of condoms, the next most effective method. The resulting overall failure rate would be 2.4 percent per year, or about 60 percent of the level to be expected if all current IUD users stayed with their method.

Scenario 2 recognizes that although sterilization may be a sensible option, many IUD users are not yet ready to choose it. Instead, the scenario assumes that all those who can use the pill adopt it (44 percent), that three-quarters of those who cannot use the pill select the diaphragm or spermicides (the next most effective methods whose use is controlled by the woman), and that one-quarter are protected by condoms. Such changes would be associated with a combined annual failure rate of 9.2 percent, or more than twice the pregnancy rate of IUD users if they made no change.

Scenario 3 represents what is probably the most likely course of events. This option assumes that the post-IUD pattern of contraceptive use will be similar to the pattern observed among women who discontinued IUD use in 1980–1982 and remained exposed to the risk of unintended pregnancy (see Table 2). The pregnancy rate under this scenario is very high—13.0 percent, or three times the rate otherwise expected. Three-quarters of the resulting unintended pregnancies would be contributed by the 15 percent of women not using any contraceptive.

The implications of the three scenarios make it clear that women who no longer have access to the IUD must make some difficult choices. Sterilization entails the lowest risk of pregnancy; but 45 percent of current IUD users say they want another child, and at least some of the remaining 55 percent may not be ready for this final step. Already, 10

Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults With AIDS

study duration
1 to 3 years

Margaret A. Fischl, MD; Gordon M. Dickinson, MD; Gwendolyn B. Scott, MD; Nancy Klimas, MD; Mary Ann Fletcher, PhD; Wade Parks, MD, PhD

Forty-five adults with the acquired immunodeficiency syndrome (AIDS) and their 45 spouses, 100 children, and 29 household contacts were studied for evidence of heterosexual, perinatal, and household spread of human T-cell lymphotropic virus type III (HTLV-III) infection. Of the 45 spouses enrolled, 26 (58%) had antibody to HTLV-III, including 12 (71%) of 17 male spouses and 14 (50%) of 28 female spouses. Of the 12 seropositive male spouses, nine were seropositive at enrollment and three had seroconversion. Of the 14 seropositive female spouses, four were seropositive at enrollment and ten seroconverted. Lack of barrier contraceptive use and oral sex were associated with seroconversion. Of the 100 children enrolled, 15 had AIDS or an AIDS-related illness, two had evidence of passive transfer of maternal antibodies, and two had HTLV-III infection acquired outside the household. None of the 90 seronegative children seroconverted. Of 29 household contacts studied, none developed antibody to HTLV-III.

(JAMA 257:640-644)

THE ACQUIRED immunodeficiency syndrome (AIDS) is a recently recognized syndrome caused by human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV).[1,2] The majority of persons with AIDS fall into groups with identifiable risk characteristics: homosexual or bisexual men, intravenous drug users, blood transfusion recipients, persons with hemophilia, and infants born to mothers with HTLV-III/LAV infection.[3-6]

There has also been an increasing number of persons with AIDS whose only risk factor has been heterosexual contact with a person known to have AIDS or a person at risk for AIDS.[6-8] Subsequently, several reports have documented heterosexual transmission of HTLV-III/LAV to female spouses of patients with AIDS or AIDS-related complexes (ARCs), demonstrating that heterosexual contact is associated with male-to-female transmission of HTLV-III/LAV.[6-8] Recent reports from Africa, Haiti, and the United States suggest that significant female-to-male transmission may also occur through contact with female prostitutes.[6-8] Though these data support the concept that heterosexual contact is a route of transmission for HTLV-III/LAV, the efficiency and risk factors or mechanisms associated with the heterosexual transmission of HTLV-III/LAV are still unknown.

The prevalence of antibody to HTLV-III/LAV in the general population is low, less than 1%.[9] Although the virus has been isolated from saliva and tears,[10] to date there has been no documentation of "casual" spread of the virus.[9] Several important questions about the transmission of HTLV-III/LAV remain unanswered. Families with one or more members infected with HTLV-III/LAV present a unique opportunity to assess the spread of the virus to sexual partners, children, and other household members. This report summarizes our experience with 45 patients with AIDS and their families.

SUBJECTS AND METHODS

Study Population

Adult patients with AIDS diagnosed at our medical center were identified and followed up prospectively. These patients with spouses or heterosexual partners of more than one month's duration were eligible for the study. Only index patient-spouse/partner pairs were enrolled, along with all children of the index patient and spouse/partner and all household members.

The *index patient* was defined as the adult person initially identified to have AIDS. *Spouse* referred to a woman or man living with the index patient as a wife or husband at the time of the diagnosis of AIDS in the index patient. A heterosexual partner referred only to a partner with whom the index patient had had sexual contact for more than one month. Spouses and partners found to have an independent risk factor for HTLV-III/LAV infection were excluded. *Children* were defined as natural children, stepchildren, and adopted children of the index patient or spouse/partner. *Household members* refers to persons living with the index patient at the time of diagnosis of AIDS who were not sexual contacts or children of the index patient or spouse/partner.

We defined AIDS in adults and infants by the Centers for Disease Control (Atlanta) definition.[11,12] Criteria for the diagnosis of ARC in adults and infants were previously published.[6]

Methods

All spouses, children, and household members were enrolled and examined at the time of the diagnosis of AIDS in the index patient and followed up every four to six months thereafter for one to three years. Evaluation included a medical history, physical examination, standardized epidemiologic interview, and laboratory tests. Only adult participants were interviewed. Interviews consisted of questions related to socioeconomic status, medical history, current health, life-style, sexual practices, and interactions with children and household members. Laboratory tests included a complete blood cell count with differential, T-lymphocyte markers, T-lymphocyte subset ratio, quantitative immunoglobulins, and serologic tests for syphilis, hepatitis B, and HTLV-III/LAV.

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T lymphocytes and T-lymphocyte markers were quantitated as previously reported.[8] Immunoglobulin levels were measured by nephelometry.

Hepatitis B surface antigen and antibodies to hepatitis B surface and core antigens were measured by radioimmunoassay. Antibodies for syphilis were measured by fluorescent treponemal antibody.

The method for assessment of antibody response to HTLV-III/LAV employed radioimmunoprecipitation of the major internal protein, p24,[9] as well as immunoprecipitation of solubilized infected extracts labeled with methionine tagged with sulfur ...[10] Serum samples were defined as positive on the basis of reactivity with at least one and, more commonly, both envelope and polypeptides. Antibodies to HTLV-III/LAV were also determined by an enzyme immunoassay. All serum samples were tested in triplicate. All repeatedly positive samples were confirmed with Western blot analysis.[9]

Statistical testing included Student's *t* tests or Fisher's exact test. Multivariate logistic regression analyses were also used to look for associations, interactions, and confounding. Sexual activities were evaluated and analyzed as a positive or negative response, frequency of total sexual activity, and percentage of total sexual activity during specified intervals.

RESULTS

Characteristics of the Study Population

Forty-five adult patients with AIDS and their 45 spouses, 109 children, and 29 adult household members were enrolled between January 1983 and June 1985. The median length of follow-up was 24 months, ranging from 12 to 36 months. Of the 45 index patients enrolled, nine used intravenous drugs, nine were heterosexual with either a prior sexual partner with HTLV-III/LAV infection or a history of frequent heterosexual contacts, four were bisexual, four had received blood transfusions, and two had hemophilia A. Seventeen without other risk characteristics were Haitian immigrants. Seventeen were women, and 28 were men. Ages ranged from 24 to 54 years, with a mean age of 33.0 ± 6.4 years.

Forty-five spouses were enrolled (Table 1). No risk factor for HTLV-III/LAV infection other than contact with the index patient was noted. Sixteen spouses were Haitian immigrants. Seventeen were men, and 28 were women. Ages ranged from 19 to 49 years, with a mean age of 31.6 ± 7.2 years.

All couples had been married for at least one year (range, one to 28 years; median, five years) and were sexually active at the time of enrollment in the study. Ten no longer had sexual contact after the diagnosis of AIDS was made in the index patient. Twelve continued to have sexual contact with barrier contraceptives, and 23 continued to have sexual contact without barrier contraceptives. *Barrier contraceptives* refer to condoms only.

Prevalence of Antibody to HTLV-III/LAV Among Spouses

Of the 45 spouses enrolled, 13 (29%) had antibody to HTLV-III/LAV at enrollment into the study (Table 2); nine were men, and four were women. Of the 32 spouses who were seronegative at enrollment, 13 (41%) developed antibody to HTLV-III/LAV during the course of the study; three were men and ten were women. Antibody persisted in all spouses. Among the spouses who had seroconversion, antibody to HTLV-III/LAV was detected after six to 18 months of follow-up. In the three male spouses who had seroconversion, AIDS in the index case was related to blood transfusions in two and intravenous drug use in one.

Correlation of HTLV-III/LAV Antibody With Sexual Practices

Of the 26 HTLV-III/LAV–seropositive spouses, 14 participated in vaginal intercourse only and 12 participated in vaginal intercourse and oral sex. Three also participated in anal intercourse.

Of the ten spouses no longer having sexual contact after enrollment, two were already seropositive for HTLV-III/LAV at entry into the study, and none of the remaining eight had seroconversion during the study (Table 3). Two of the 12 spouses who used barrier contraceptives after enrollment were seropositive for HTLV-III/LAV at entry into the study, and one of the remaining ten had seroconversion during the study. Of the 23 spouses not using barrier contraceptives after enrollment, nine were seropositive at entry into the study and 12 of the remaining 14 spouses had seroconversion during the course of the study. (The use of barrier contraceptives reflects routine use during vaginal intercourse. Spouses who used barrier contraceptives intermittently were not distinguishable from spouses not using barrier contraceptives.) Barrier contraceptive use prior to enrollment into the study was difficult to evaluate because of erratic use. Only three spouses used barrier contraceptives regularly during a two- to five-year period prior to enrollment; all three were seronegative for HTLV-III/LAV.

Spouses who were seropositive for HTLV-III/LAV were more likely to have participated in repeated oral sex, not to have used barrier contraceptives, to have a history of gonorrhea, and to have a positive test for syphilis (Table 4). (Repeated oral sex was defined as at least two such contacts per month or 50% or more of total sexual activity.) The length of sexual contact, number of contacts per week, and other types of sexual activity did not correlate with antibody to HTLV-III/LAV (Table 4).

Male spouses who were seropositive for HTLV-III/LAV at enrollment and follow-up were more likely to have a history of gonorrhea and a positive test for syphilis (Table 4). In eliminating those male spouses with other heterosexual partners, no specific factor tested correlated with antibody to HTLV-III/LAV. Female spouses who were seropositive for HTLV-III/LAV at enrollment and follow-up were more likely to have participated in repeated receptive oral sex and not to use barrier contraceptives. No correlation between antibody to HTLV-III/LAV and the prevalence of cervicitis, vaginitis, intercourse during menstruation, or hygienic practices were noted.

Clinical and Immunologic Findings Among Spouses

Nineteen spouses (42%) developed clinical disease one to 12 months after enrollment in the study. All were seropositive for HTLV-III/LAV. Nine spouses (four male and five female) had lymphadenopathy alone. Six (five male and one female) developed an AIDS-related illness and four (two male and two female) developed AIDS. Of the 13 spouses who had seroconverted during the study, none had symptoms or signs of an "acute" retroviral infection.

A decreased number of T-helper cells, an inverted T-lymphocyte subset ratio, and increased serum levels of IgG correlated with HTLV-III/LAV antibody (Table 5). Two HTLV-III/LAV seronegative spouses had inverted T-lymphocyte subset ratios, and three had increased serum levels of IgG. All spouses who had seroconversion had normal numbers of T-helper cells and T-lymphocyte subset ratios at the time HTLV-III/LAV antibody was detected. During a three- to 18-month follow-up period, 60% were noted to have a decrease in the number of T-helper cells with or without an increase in T-suppressor cells. (The mean ± SD number of T-helper cells measured at enrollment was 541.5 ± 52.1 compared with 308 ± 71.1 at follow-up.)

Table 1.—Demographic and Clinical Characteristics of Spouses*

Spouse	No.	Age, y	Sex	Risk Factor of Index Patient	Length of Contact Before Dx, y	Length of Contact After Dx, mo	Length of Follow-up Since Dx, mo	HTLV-III at mo 0	6	12	18
1	25	M		Prostitute	3	4	20	+	+	+	+
2	42	M		Homo†	6	?	22	+	+	+	+
3	29	M		Homo†	6	20	36	+	+	+	+
4	29	M		Homo†	2	34	36	+	+	+	+
5	24	M		Homo†	6	10	136	+	+	+	NT
6	33	M		Homo†	15	25	36	+	+	+	+
7	39	M		Homo†	3	14	138	+	+	+	NT
8	36	M		Homo†	6	34	246	+	+	+	+
9	39	M		IV drug use	3	18	18	–	–	–	+
10	44	M		Blood transf	2	9	18	–	–	+	NT
11	29	M		Homo†	3	0	13	–	–	–	NT
12	36	M		Homo†	4	9	12	–	–	–	NT
13	37	M		IV drug use	6	0	11	–	–	–	NT
14	31	M		Prostitute	6	6	12	+	+	+	NT
15	36	M		IV drug use	5	13	13	–	–	–	NT
16	36	M		Prostitute	2	12	12	–	–	–	NT
17	44	M		Blood transf	3	14	14	–	–	+	NT
18	29	F		Homo†	3	19	36	–	–	–	–
19	29	F		Homo†	2	6	26	–	–	–	–
20	54	F		Homo†	6	23	26	–	–	–	–
21	25	F		Homo†	15	11	22	–	–	+	+
22	11	F		Bisexual	20	19	36	–	–	–	–
23	36	F		IV drug use	10	20	36	–	–	–	+
24	31	F		Homo†	4	10	10	–	–	–	–
25	49	F		Homo†	20	0	20	–	–	–	–
26	34	F		Homo†	3	22	22	+	+	+	+
27	28	F		IV drug use	12	0	23	–	–	–	–
28	46	F		IV drug use	6	0	17	–	–	–	NT
29	33	F		Hemophilia A	15	0	12	–	–	–	NT
30	45	F		Homo†	2	10	10	–	–	+	NT
31	19	F		Bisexual	1	0	10	–	–	–	NT
32	39	F		Homo†	6	8	14	–	–	+	NT
33	47	F		Blood transf	6	6	12	–	+	+	NT
34	39	F		Homo†	6	11	11	–	+	+	NT
35	41	F		IV drug use	2	12	12	–	+	+	NT
36	33	F		Bisexual	3	0	16	+	+	+	NT
37	35	F		Homo†	10	15	15	–	–	–	NT
38	39	F		Homo†	2	28	30	+	+	+	+
39	39	F		Homo†	6	11	12	–	+	+	NT
40	34	F		Homo†	4	7	11	–	+	+	NT
41	39	F		Hemophilia A	6	11	16	–	–	–	NT
42	19	F		Blood transf	2	11	16	–	–	–	NT
43	47	F		Bisexual	14	17	28	–	–	+	NT
44	39	F		IV drug use	2	7	11	–	+	+	NT
45	34	F		IV drug use	2	14	14	+	+	+	NT

*Dx indicates diagnosis; NT, not tested; IV, intravenous; and transf, transfusion. Length of contact before diagnosis reflects the number of years reported before the diagnosis of acquired immunodeficiency syndrome was made in the index patient. Length of contact after diagnosis reflects months of sexual contact between spouses after diagnosis. Discrepancy between length of contact and follow-up reflects abstinence on the part of the couple or death of the index patient.

†Homosexual contact, previous spouse or partner.
‡Presumed Haitian transfusion.
§Died.
‖Unavailable for follow-up.
¶Heterosexual contact, female prostitutes.

Table 2.—Prevalence of Antibody to HTLV-III Among Spouses

	No. Positive/Total No. (%)		
	At Entry	Seroconversion	Total
Total	13/45 (29)	13/32 (41)	26/45 (58)
Male	9/17 (53)	3/8 (38)	12/17 (70)
Female	4/28 (14)	10/24 (42)	14/28 (50)

Table 3.—Relationship of Sexual Activity to Development of HTLV-III/LAV Antibody Among 32 Spouses Seronegative on Enrollment

Sexual Activity	No.	HTLV-III Antibody, No. (%) Positive	Negative
Abstinence	8	0 (0)	8 (100)
Sexual contact with barrier contraceptive	10	1 (10)	9 (90)
Sexual contact without barrier contraceptive	14	12 (86)	2 (14)

Epidemiologic, Serologic, and Immunologic Data Among Children

Of the 109 children enrolled, 66 were girls and 43 were boys. Ages ranged from 3 months to 24 years. Three had AIDS, ten had ARC, and two had persistent generalized lymphadenopathy at the time of enrollment in the study. Six have been described in detail elsewhere.[9] All 15 children with AIDS, ARC, or persistent generalized lymphadenopathy were less than 4 years of age, were HTLV-III/LAV antibody positive, and had been born to HTLV-III/LAV–positive mothers. Two infants who were clinically and immunologically normal had antibody to HTLV-III/LAV when first tested at 3 and 6 months of age. Both became seronegative for HTLV-III/LAV after 12 to 18 months of follow-up, suggesting passive transfer of maternal antibodies.

Two older children born to a father with AIDS and a seronegative mother had antibody to HTLV-III/LAV. Both were sexually active young adults of Haitian ancestry who had spent approximately 13 years in Zaire before entering the United States. The natural father of both children had antibody to HTLV-III/LAV and AIDS. The natural mother of both children was seronegative for HTLV-III/LAV and had spent little time in Zaire with her family.

Ninety children were seronegative for HTLV-III/LAV at entry into the study. All interacted closely with their parents and other siblings through hugging, kissing, and sharing of kitchen and bathroom facilities. Twenty-three of these children had "shotty" lymphadenopathy (lymph nodes measuring less than 1 cm in diameter in two noncontiguous sites) and/or inverted T-lymphocyte subset ratios at entry into the study. All 90 infants remained negative for HTLV-III/LAV antibody.

Epidemiologic, Serologic, and Immunologic Data Among Household Members

Twenty-nine adult household members (adult relatives of the index patient or spouse) were enrolled in the study. All had close contact with the index case, spouse, and children in the household, including personal contacts through hugging, kissing, and sharing of kitchen and bathroom facilities. Twenty were directly involved in the care of the index patient or children with AIDS or ARC. In each case, the household member was clinically and immunologically normal. All remained negative for HTLV-III/LAV antibody.

Table 4.—Correlation of Sexual Activities and Other Factors With Antibody to HTLV-III Among Seropositive and Seronegative Spouses*

Variable	HTLV-III Seropositive (N = 28)	HTLV-III Seronegative (N = 13)	P
All Spouses			
Length of contact, y	5.7 ± 4.0	7.6 ± 7.2	.27
No. of contacts/mo	2.7 ± 0.9	2.3 ± 0.7	.11
Vaginal sex	26	19	NS
Repeated oral sex	12	2	< .001
Anal sex	3	2	.97
Condom use	3	10	< .001
Gonorrhea	7	0	.02
Syphilis	6	0	.03
Vaginitis	8	9	.34
Cervicitis	0	1	.15
Male Spouses			
Repeated oral sex	2	1†	.88
Gonorrhea	6	0	.06
Syphilis	6	0	.06
Female Spouses			
Repeated oral sex	11	1	< .001
Gonorrhea	1	0	.39
Syphilis	0	0	NS

*Values are expressed as means ± SDs or the number of spouses with a positive response. NS indicates not significant.

Table 5.—Immunologic Studies Among HTLV-III/LAV Seropositive and Seronegative Spouses

	Seropositive Spouses (N = 28)*	Seronegative Spouses (N = 13)*	Normal Range
Lymphocyte count/mm³ (× 10⁹/L)	1999 ± 904 (2.0 ± 0.9)	2683 ± 894 (2.7 ± 1.0)	1000–4000 (1.5–4.0)
T-helper cell/mm³ (× 10⁹/L)	499 ± 399 (0.5 ± 0.3)	1053 ± 496 (1.1 ± 0.5)	496–1439† (0.5–1.4)
T-lymphocyte ratio	0.8 ± 0.6	1.8 ± 0.8	1.0–3.0†
Serum IgG, mg/dL (g/L)	2066 ± 1148 (20.66 ± 11.48)	1344 ± 418 (12.44 ± 4.18)	639–1349 (63.89–134.90)

*Values are expressed as means ± SDs and were measured at entry into the study or at the time of seroconversion. †P < .001.

COMMENT

The overall incidence of HTLV-III/LAV infection among spouses of index patients in this study was 58%, demonstrating a high rate of transmission of HTLV-III/LAV among heterosexual couples. In seven of the spouses there was a history of other heterosexual partners. It is possible in some instances that the spouse may have acquired HTLV-III/LAV infection outside the household and may themselves have been the primary source of infection. When spouses with other heterosexual partners were eliminated from the data analyses, the incidence of HTLV-III/LAV infection among spouses was still high (50%). Thirteen spouses were already seropositive for HTLV-III/LAV at enrollment in the study. This is not surprising in view of the length of contact between couples prior to evaluation. Thirty-two spouses were seronegative for HTLV-III/LAV at enrollment. Although patients were counseled, several continued to have sexual contact, and 13 (41%) developed antibody to HTLV-III/LAV during the course of the study. Seroconversion occurred throughout the study. Since the exact time of onset of HTLV-III/LAV infection in the index patients was not known, it was unclear how long spouses had sexual contact before developing antibody. Although it has been suggested that HTLV-III/LAV viremia may decrease over time in patients with AIDS, these data demonstrate that spouses who continue to have sexual contact with an infected partner are at risk for acquiring virus. It is possible that changes in sexual behavior or other cofactors in either the index patients or spouses affected subsequent seroconversion. For example, seroconversion occurred more commonly in female spouses, two of whom were pregnant.

We also investigated any possible association between gender and secondary infection with HTLV-III/LAV. Eight male spouses were seronegative for HTLV-III/LAV at enrollment; three had seroconversion during the study. In each instance, the female index patient had acquired HTLV-III/LAV infection from either blood transfusions or previous intravenous drug use. There was no identifiable risk factor for HTLV-III/LAV infection in the three male spouses, nor did they have other sexual partners. These findings strongly support female-to-male transmission of HTLV-III/LAV in these men. These data, along with those of Redfield et al[10] and others[11,12] further document that HTLV-III/LAV is a bidirectionally transmitted virus.

A difference in the seroprevalence rate for HTLV-III/LAV antibody was noted between male and female spouses at enrollment in the study; nine (52%) of 17 male spouses had antibody to HTLV-III/LAV compared with four (14%) of 28 female spouses. The higher prevalence of HTLV-III/LAV infection in male spouses at enrollment may be attributable to other factors, such as frequent other heterosexual contacts. Multiple other heterosexual partners were not noted among female spouses. When the seven male spouses with a history of other heterosexual partners were eliminated from the analyses, there was no significant difference between the seroprevalence rate of antibody to HTLV-III/LAV at enrollment among female spouses (four [14%] of 28) and male spouses (two [20%] of ten). Further, we found that the seroconversion rate for male spouses (42%) was similar to that for female spouses (38%). These findings suggest that HTLV-III/LAV may be transmitted heterosexually in either direction with a similar efficiency. The generally noted higher prevalence of HTLV-III/LAV antibody among men may simply reflect greater exposure to HTLV-III/LAV through a larger number of partners. With an increasing incidence of HTLV-III/LAV infection among intravenous drug users and female prostitutes and the presence of a small but definite number of persons with HTLV-III/LAV infection related to blood transfusion, an increase in the heterosexual transmission of HTLV-III/LAV can be expected if immediate measures for education and risk reduction are not implemented.

We were also interested in any risk factors associated with the heterosexual transmission of HTLV-III/LAV. Relative to specific sexual activities, we noted that in more than half of the couples the only type of activity practiced was vaginal intercourse. Therefore, it is apparent that vaginal intercourse alone is sufficient for the heterosexual transmission of HTLV-III/LAV. Anal intercourse was not a common practice and did not appear to play a significant role in the heterosex-

ual transmission of HTLV-III/LAV. Among female spouses, repeated receptive oral sex correlated with the presence of antibody to HTLV-III/LAV, suggesting that this may be a potential mode of heterosexual transmission of HTLV-III/LAV. Whether oral sex alone is sufficient for the heterosexual transmission of HTLV-III/LAV could not be determined from this study, as couples also participated in vaginal intercourse. It did not appear that these couples were more sexually active. However, these data suggest that either the amount or route of viral exposure may play an important role in the heterosexual transmission of HTLV-III/LAV.

Twelve of the 14 spouses who continued to have sexual intercourse without barrier contraceptives seroconverted during the study. This was strikingly different from the absence of seroconversion in the eight couples abstaining from sexual intercourse and the single conversion in the ten couples who used barrier contraceptives. These data suggest that continued heterosexual contact without preventive measures will result in HTLV-III/LAV infection and that sexual contact with barrier contraceptive may decrease the risk of transmission. Whether or not barrier contraceptives truly prevent the transmission of HTLV-III/LAV, however, will need further study.

The risk of immunologic abnormalities and clinical disease in spouses with HTLV-III/LAV infection was high (42%). Several spouses without evidence of HTLV-III/LAV infection, however, had isolated clinical or immunologic abnormalities such as lymphadenopathy and inverted T-lymphocyte subset ratios. These findings most likely reflect intercurrent infection in the household other than HTLV-III/LAV.

The examination of children demonstrated that only HTLV-III/LAV–seropositive mothers had infants with clinical and serologic evidence of HTLV-III/LAV infection. All but two children of seronegative mothers and seropositive fathers were clinically and immunologically normal and did not develop antibody to HTLV-III/LAV. In two children, tests for HTLV-III/LAV antibody were positive. Both were from the same household and were sexually active young adults (19 and 24 years of age) of Haitian ancestry who had spent more than ten years in Zaire. We therefore cannot determine if these findings represent household spread, sexual transmission, or a source of exposure outside of the household. Based on these subjects' household interaction, sexual activities, and travel to Zaire, we believe these cases may represent HTLV-III/LAV acquired outside the home.

Two infants had transient antibody to HTLV-III/LAV, which suggested passive transfer of maternal antibodies rather than transplacental infection. Both infants were clinically and immunologically normal, and antibody disappearance was noted after 12 and 18 months of follow-up, which is considerably longer than anticipated for the disappearance of maternal antibodies. Infants with antibody to HTLV-III/LAV who are clinically and immunologically normal may need to be followed up for at least one to two years before a diagnosis of transplacental infection can be made.

Of 90 HTLV-III/LAV–seronegative children at entry into the study, there was no evidence of horizontal transmission. In particular, we found that unaffected siblings of children with AIDS or ARC did not have or develop antibodies to HTLV-III/LAV. These data, along with others,[*] continue to support the concept that HTLV-III/LAV is not spread through close contact other than intimate sexual or blood exposures. These observations are important and suggest that contact in other settings (for example, schools) is not likely to transmit HTLV-III/LAV.

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Mr. WAXMAN. Thank you very much. Mr. Rosenberg.

STATEMENT OF MICHAEL J. ROSENBERG

Mr. ROSENBERG. Thank you, Mr. Chairman.

My name is Michael Rosenberg. I am also a practicing physician, and I am the Executive Director of the American Social Health Association. ASHA is a national non-profit organization which has been involved in the field of sexually-transmitted diseases for 75 years.

There are three points basically that I would like to make with you this morning. First is that there is a sizeable body of scientific literature which is growing even as we speak that condoms provide effective protection against a variety of sexually-transmitted diseases.

Second, that promoting sexual abstinence is the only alternative to protect against disease is unlikely to be successful in curbing the alarming increase in AIDS and other sexually-transmitted diseases.

And finally, that rates of other sexually-transmitted diseases are increasing at a disturbing rate, indicating the need for more effective efforts at prevention. Education about condoms, spermicides, and other preventive measures are critical to reducing the formidable toll of these diseases on men, women, and children.

Numerous studies consistently indicate that couples who use condoms have a reduced risk of contracting a variety of sexually-transmitted diseases, compared to couples who do not. One of the first large studies was done in France in the early 1970's among sexual partners of over 700 women who were infected with gonorrhea or trichomoniasis. Of the 302 men who used condoms, less than 1 percent got gonorrhea, and about 2 percent got Trichomonas. The 480 men who were not using condoms, 97 percent got gonorrhea, and 33 percent contracted trichomoniasis.

A second similar study was conducted in Vietnam among 55 men who always used condoms, none of whom became infected with any sexually-transmitted diseases. Among 191 who did not, 35 percent contracted at least one sexually-transmitted disease.

There is a fairly extensive literature, which I'm not going to continue into here, but which is fairly consistent in indicating a rather strong degree of protection against sexually-transmitted diseases.

This evidence which I've recounted for you is also consistent with laboratory evidence, which indicates that condoms are impermeable to all types of sexually-transmitted diseases studied. That includes viruses, in which I include HIV, the virus responsible for AIDS, also bacteria, Chlamydia and spirochetes which are associated with syphilis.

More to the point of this hearing, though, there is some date which we have already heard reviewed briefly which indicates that condoms also afford protection against infection with HIV. A letter in last week's New England Journal of Medicine indicated that among Zairean prostitutes, when their partners used condoms at least 50 percent of the time, they were substantially less likely to be seropositive than among women whose partners did not use condoms that often.

The other report is from this week's Journal of the American Medical Association, which followed a number of heterosexual partners. Among 10 couples who used condoms, 1 out of those 10 or

10 percent sero-converted, where among 14 couples who did not use condoms, 12 out of 14 or 86 percent became infected.

So in summary, then, there is fairly solid scientific evidence which indicates that condoms do provide substantial degrees of protection.

The second point I'd like to make regarding disease protection is that when we talk about the efficacy of condoms in preventing disease, we're really talking about the user's ability and motivation to use them consistently and correctly. The information that we have and that we've heard cited this morning really refers to condoms in the context of avoiding pregnancy and not so much in the context of avoiding sexually-transmitted diseases, and I would submit that there may be a substantial degree of difference in the motivation of somebody who is using a condom to prevent the spread of a potential fatal disease to a partner than in having their partner become pregnant.

The problem is that we don't really know the answers to these things. We do know that in highly motivated couples, condoms are about 97 to 98 percent effective in preventing pregnancy. And I think it stands to reason that when you are concerned about a more serious disease, a potentially lethal disease, that the effectiveness can potentially be even greater.

The second point this morning is that advocating sexual abstinence for everyone is unlikely to be an effective means of preventing disease. Dr. Koop has pointed out the feeling of immortality among young people, which makes them unafraid of serious diseases including AIDS. Our experience at ASHA in dealing with 75 years of sexually-transmitted diseases, although everyone would prefer to abstain from sex, the reality is that sex is occurring at younger ages, and marriage is occurring at older ages now. The result of that, along with the baby boom generation coming of age, is that there is a larger population of people at risk for sexually-transmitted diseases now than ever before.

While abstinence may be a viable alternative for some people, it is not, in my view, realistic to expect of everyone.

The final point I would like to make is that numerous other sexually-transmitted diseases, which receive much less attention than AIDS, but which affect millions of Americans, are rising at somewhat alarming rates now. Over the past several years, control of other sexually-transmitted diseases has been drained as energies have focused on AIDS. Despite the fact that there are an estimated 12 million new cases of sexually-transmitted diseases every year, appropriations to research prevention and control measures have barely kept pace with inflation.

Condoms can help control these sexually-transmitted diseases as well as AIDS. Another preventive measure is the use of spermicides, similarly effective against a variety of sexually-transmitted pathogens.

But the most important and immediate step is the education which must accompany these efforts. To that end, ASHA is cosponsoring a conference next week, along with the Centers for Disease Control and Family Health International, on condoms in the prevention of sexually-transmitted diseases. We expect that conference to review past literature, but most importantly, there is a very

quickly emerging body of literature which we expect have presented at that meeting, and most of that information is not published yet.

Mr. Chairman, we have to face reality, and until vaccines are available for many of the important sexually-transmitted diseases today, we need to look at all possibilities to make sex safer. We can mitigate some risks. We can give some people information they need to make informed decisions about their lives and their behavior.

We are delighted that you took the initiative in calling this hearing, and thank you for the opportunity to express our views.

Mr. WAXMAN. Thank you very much for your testimony.

[The prepared statement of Mr. Rosenberg follows:]

REMARKS

BY

MICHAEL J. ROSENBERG, MD, MPH

EXECUTIVE DIRECTOR

AMERICAN SOCIAL HEALTH ASSOCIATION

Mr. Chairman, I am Michael Rosenberg, Executive Director of the American Social Health Association, a national non-profit organization which has been involved in the field of sexually transmitted diseases for 75 years. On behalf of our Board of Directors, I want to express our appreciation to you for making this hearing possible, and for giving us this opportunity to share our views.

The first historical mention of condoms comes from Egypt, when they were used as an indicator of status and for protection against non-sexually transmitted diseases such as schistosomiasis. They are mentioned sporadically throughout the next several centuries, including numerous references during the eighteenth century by Casanova and DeSade. These early devices were made from the intestines of sheep, and it was not until the vulcanization of rubber that condoms became inexpensive and widely available. During the first and second world wars, soldiers were constantly reminded of the scourge of sexually transmitted diseases. Such educational efforts contributed to more common use of condoms.

With the introduction of oral contraceptives, use of the condom declined. Currently about 14% of couples rely on the device to protect against pregnancy. Now, however, concern about sexually transmitted diseases has, once again, encouraged couples to utilize condoms for protection against infection.

With that historical perspective in mind, I would like to make three points before the Committee this morning:

First, that a sizeable body of scientific literature indicates that condoms provide effective protection against a variety of sexually

transmitted diseases;

Second, that promoting sexual abstinence as the only alternative to protecting against disease is unlikely to be successful in curbing the alarming increase in AIDS and other sexually transmitted diseases; and

Third, that rates and incidence of other sexually transmitted diseases are increasing at a disturbing rate, indicating the need for more effective efforts at prevention. Education about condoms, spermicides, and other preventive measures are critical to reducing the formidable toll of these diseases on women and children.

Numerous studies consistently indicate that couples who use condoms have a reduced risk of contracting a variety of sexually transmitted diseases when compared to couples who do not. One of the first large studies was done in France in the early 1970s, among sexual partners of over 700 women infected with gonorrhea or trichomoniasis. Of the 302 men who claimed to consistently use condoms, less than 1% contracted gonorrhea, and 2% contracted trichomoniasis. A second study was conducted among soldiers in Vietnam, and found that none of the 55 men who said that they always used condoms became infected with a sexually transmitted disease, while 35% of the 191 who did not use condoms contracted one or more STD. More recently, protection against gonorrhea has been confirmed among condom users. In addition, condoms have been shown to have substantially reduced or eliminated risk of contracting a variety of other sexually transmitted diseases, including herpes, chlamydia, nongonococcal urethritis, and HIV infection.

This is consistent with laboratory evidence which also shows

that condoms are impermeable to all types of STDs studied, including viruses, bacteria, chlamydia and spirochetes.

More to the point of this hearing, data is just emerging which indicates that condoms afford protection against infection with HIV. A letter in last week's New England Journal of Medicine indicated that among Zairian prostitutes, those whose partners used condoms more than 50% of the time were significantly less likely to be infected with HIV than those whose partners used condoms less frequently. A second report from this week's Journal of the American Medical Association followed 45 heterosexual couples in which one partner was infected with AIDS. Of the ten couples who used condoms, one (10%) became seropositive during the study period (although since then 2 more spouses have seroconverted). In contrast, 14 couples continued relations without condoms, and 12 (86%) became infected.

In summary, there is solid scientific evidence which indicates that condoms provide substantial protection against sexually transmitted infection.

The efficacy of condoms in preventing disease depends on the users' ability and motivation to use them consistently and correctly. The most complete indication of how effectively couples use condoms comes from their use in preventing pregnancy. Motivation among couples wishing to avoid pregnancy and those wishing to avoid a potentially life-threatening disease are most likely different, so these rates must be interpreted with caution. Among couples using condoms for contraception, the failure rate is 10-20%. However, in highly motivated couples, the failure rate is as low as 1-2%.

My second point is that advocating sexual abstinence for everyone is

unlikely to be an effective means of preventing disease. Sex, it is said, is a third priority after personal safety and food. Dr. Koop has pointed out the feeling of immortality among young people, which makes them unafraid of fatal diseases, including AIDS. Our experience at ASHA in dealing with 75 years of sexually transmitted diseases is that although everyone would prefer that young people delay sex, the reality is that sex is occurring at younger ages and marriage occuring later. We must deal with the reality that there is a tremendous population of sexually active young people and adults, and that they are at risk for sexually transmitted diseases. While abstinence may be a viable alternative to some people, it is not, in my view, realistic to expect of everyone.

Condoms may not be a perfect alternative, and they are certainly no guarantee, but we must inform people that there are some benefits to their use when used consistently and correctly.

Finally, I must point out that numerous other sexually transmitted diseases, which receive much less atention than AIDS but which affect millions of Americans, are rising at alarming rates. Over the past several years resources for the control of the other STDs have been drained as energies have focused on AIDS. Despite the fact that there are an estimated 12 million new cases of STDs each year, appropriations to research, prevent and control the diseases have only barely allowed the STD control program to keep syphilis and gonorrhea under control. Funding has not allowed any new prevention or control initiatives.

In fiscal year 1985, rates of gonorrhea increased for the first time in a decade. Antibiotic resistant strains of gonorrhea have skyrocketed and now are present in every state, which triples the cost of treatment. CDC estimates that there are more than 4 million new cases of chlamydia

each year, a disease that can lead to sterility and ectopic pregnancy in women, and can cause pneumonia and blindness in newborns. More than 20 million Americans suffer from genital herpes. Human papilloma viruses are probably the most prevalent STD and have been association with genital cancers. More than 7,000 women die each year of cervical cancer. Approximately 80,000 ectopic pregnancies occurred in 1984. At least half of them were attributable to pelvic infection caused by an STD. As gonorrhea and chlamydia have increased since then, it can be expected that rates of ectopic pregnancy will continue to climb.

Condoms can help control these sexually transmitted diseases as well as AIDS. Another preventive measure is the use of spermicides, similarly effective against a variety of sexually transmitted pathogens. But the most important and immediate step is the education which must accompany these efforts.

To that end, ASHA is co-sponsoring a conference next week along with the Centers for Disease Control and Family Health International on Condoms in the Prevention of Sexually Transmitted Diseases. We expect that conference to review the newest, yet unpublished, information relating condoms to prevention against STDs, including AIDS.

Mr. Chairman, we must face reality, and until vaccines are available for any of the sexually transmitted diseases we must educate the public about any and all possibilities to make sex safer. We can mitigate some risks, and we can give people information they need to make informed decisions about their lives and their behavior.

We commend you for bringing this important issue before the public and we thank you for the opportunity to express our views.

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Mr. WAXMAN. As I understand what you're saying, Dr. Rosenberg, is that condoms do provide a substantial amount of protection.

Now, Dr. Crenshaw, as I understand what you're saying is, even if there's a substantial amount of protection, it's not complete protection.

Do you disagree with that? Is that where you're both coming from? Is that the way you——

Ms. CRENSHAW. That's the gist of what I'm saying, yes. You reported it accurately.

Mr. WAXMAN. Now while we prefer, if there's the danger of a terrible disease, that people try to protect themselves as completely as possible, we also hope that people, if they don't do the maximum to protect themselves, will do the next amount that will lessen the chance of spreading the disease. The worst, of course, is if people do things that will increase their chances, not only to get the disease but to spread it further.

Dr. Rosenberg, it has been suggested that condoms should not be promoted because they are not fail-proof. Do you agree with that?

Mr. ROSENBERG. Well, I don't. It's a question of relative versus absolute risk. I think there are very few things in life which afford us absolute protection against anything. And I think the realities are, if there is something which, as you just stated, provide a substantial degree of protection, that that should be at least made known to the public. And I think the case is now that that information is not generally appreciated.

Mr. WAXMAN. Now you suggest in your testimony that condom failure is often user failure. When condoms are used properly, how reliable are they?

Mr. ROSENBERG. As I have stated, they are far more effective than some of the numbers we've heard this morning. In highly motivated couples, there as effective—the lowest that I've seen is a 0.7 percent failure rate. That means less than 1 percent of couples became pregnant over a year's time.

The other point is that those studies have largely been done, in effect, to condoms as a means of contraception, as a means of avoiding pregnancy, rather than a means of avoiding potentially fatal disease.

Mr. WAXMAN. Now we've had testimony today that the failure rate can be as much as 10 percent. You're saying that some studies show that for people who use them correctly and are motivated to try to avoid transmissions of bodily fluids, the failure rate could be less than 1 percent, somewhere in that range.

Doesn't that mean that people ought to be educated, if they are going to use condoms, to use them effectively? Isn't telling them not to use condoms at all, in effect, hiding information about a product that, even in the worse case, protects them 90 percent of the time?

Mr. ROSENBERG. I absolutely agree with that, yes.

Mr. WAXMAN. Is there any evidence to suggest that improved marketing of condoms can reduce the rates of sexually-transmitted diseases? Do we have experience with other sexually-transmitted diseases that might conclude, with improved marketing, that this could be beneficial with this particular disease?

Mr. ROSENBERG. There is not a great deal of evidence, but there is one interesting experiment that was tried in Sweden in the early 1970s. At one point, they decided to make a push for promoting condoms, and they mounted a fairly formidable educational program, which included a lot of the advertising measures that we've been talking about this morning.

Over the next 2 years, condom usage went up 50 percent, and at the end of that 2 years, gonorrhea rates had dropped by 20 percent. So I think indirectly the answer is yes.

Mr. WAXMAN. I'm just amazed at some of the discussion we had earlier—I'm not really asking this as a question of either of the two of you—but to say to network executives that because condoms may not be effective 100 percent of the time, they shouldn't permit advertisements of the product, is ludicrous.

After all, on television we see ads for over-the-counter drugs that aren't effective 100 percent of the time. We see ads for cereals that are being promoted on the basis that the bran in the cereal can prevent cancer. Well, certainly you can't say that that would work 100 percent of the time. We don't even know how effective those claims are; we just know as a general statement on a public health basis that there is some accuracy and legitimacy to it.

I just am amazed at the kind of debate we've had.

Ms. Crenshaw, your position is, they're not effective 100 percent of the time, and therefore if you really want to protect people and people really want to make judgments as to how to avoid AIDS and other sexually-transmitted diseases, they have to understand that and act accordingly.

I don't disagree with that. Would you disagree with the idea that as a public health measure, if people are not going to engage in your recommendation of abstinence, that it's better to use condoms than not?

Ms. CRENSHAW. Oh, of course I support that. As a matter of fact, I think that putting the emphasis, asking more of them, recommending that they be exclusive, telling them that they're capable of being exclusive, will ultimately result in more people using condoms for protection, because they certainly are not going to disregard the resources that we do have, and we must use all of them.

If I might make a suggestion, I think that as we look at—or at least as some people look at the hidden agendas of condom companies and the liberal left and the radical right, we might all be able to come to common terms and agreement, if we put a little pressure on the condom companies who will benefit from this advertising financially, to include a broader message that requires that they both emphasize the value of exclusivity and point out clearly the failure rate, as we understand it today.

In that event, we'll get both messages across, I think very effectively, and then put a little pressure on the networks to use these ads.

Mr. WAXMAN. That's a very interesting suggestion. Thank you.

Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you.

Mr. Crenshaw, what means of transmissibility of the virus for AIDS is available in the literature, other than by sexual contact or intravenous drug use, of which you are aware?

Ms. CRENSHAW. Well, I think the only demonstrated ways that we are in accord about today is sexual transmission, the use of shared needles, blood products, and transfusions.

I'm concerned about many of our approaches as experts to this epidemic, because I have seen public health officials repeatedly paint themselves into corners by making absolute statements when they haven't been supportable. The same experts who are telling you today, as though there is no doubt, that the condoms have no failure rate of significance, or if that used properly, they'll be all right, once told us that heterosexuals couldn't get the disease, in spite of the evidence that we had from beginning in Africa.

I think that we all must be a little more careful because of the lives we put at risk, to say that in zones where there is some uncertainty, rather than saying it can't happen, the data is inconclusive. We have much that is still inconclusive about this disease. I think this hearing demonstrates just the debate about the failure rate of condoms, is one very good example.

And I think rather than overcorrecting in the effort to reduce panic, we must—you know, if you will listen to me as a behaviorist; if you really want to impact sexual behavior and change it, the approach isn't to calm people down and say, "Don't worry." It's to engender alarm and engender concern and then give calmness and control with the recommendations you provide on how people can remain safe.

The public health message up to now has been somewhat of a "Calm down; don't panic, and by the way, change your sexual behavior." This is not logical, and it won't work.

Mr. DANNEMEYER. What have we done wrong in terms of the public health response to deal with the epidemic of AIDS in this country?

I noticed there was some comment in your statement about it. Perhaps you can summarize those for the subcommittee at this time.

Ms. CRENSHAW. Well, I'd rather tell you what we should do right, but I will tell you——

Mr. DANNEMEYER. Put it that way.

Ms. CRENSHAW. What I've listed in here about what I think we have done wrong.

Mr. DANNEMEYER. Put it that way, then.

Ms. CRENSHAW. First of all, I must tell you that I am not impressed with the arguments that say that to encourage voluntary testing on a widespread basis would drive people underground. I mean, surely it can't be worse than it is today, when most of the experts agree that 90 percent of the people who have this virus, who are contagious, do not know it, and are spreading the disease without that knowledge.

Now if we want to control the spread of a medical epidemic, we cannot expect to do so when 90 percent of the people supposedly—I mean, we're talking in terms of millions of people who are unaware that they're infected. I think that it is very important to realize that some people will not be motivated to get tested, because there is no effective treatment at this point in time.

But I believe that will change, because with drugs like AZT, it has become apparent that those who are confirmed antibody-posi-

tives benefit from getting into research programs early. I also think that we must realize that even if there is no treatment and no cure widely available, that we can prevent this disease, but not unless the people who are infected take the responsibility to know their antibody status.

So one thing I think we must do, as a medical measure, not as a moral measure or as a restrictive measure, is to make all forms of the viral infection reportable to our Public Health Departments.

I mean, I will just give you one example. If my figures are correct—and I haven't seen these directly, but I have asked someone to look it up for me—we have fewer than a million and a half hospital beds in the Nation to take care of every ill person in our country. We have now, by conservative estimates, 2 million people infected with the AIDS virus, and according to Dr. Gallo and many others, most of these people will become ill, not 10 percent as originally thought.

There is a study out of England that has been confirmed by other studies that only 40 percent of those who are confirmed AIDS antibody-positive were asymptomatic after 3 years, and this is in a disease that takes to 5 to 7 years, some even say 10, to manifest its full power.

I think that we have made a mistake in not revealing the full scope of this epidemic to the general public, because if they don't have the knowledge about how alarming this disease really is, they are not going to get into gear to do what is difficult. I concede, changing sexual behavior requires some high incentive and strong motivation. But I can't think of a better motive than death.

I could go on probably for several hours, but I won't subject you to that. I must emphasize that we have dangerously underestimated this epidemic. I have been listening today; we're doing it still today. I think that as we speak, people are contracting this disease. They have been given the erroneous information—there are still commercials on television saying that this disease is hard to get, when there is widespread evidence that one exposure can be enough.

The artificial insemination case in Australia of women who were artificially inseminated by the same donor, all of them became antibody-positive, one exposure, atraumatic, not bleeding. We need to give this disease more respect.

Mr. WAXMAN. Thank you very much.

Mr. DANNEMEYER. I had one other question I'd like to ask Dr. Rosenberg, Mr. Chairman.

Aren't we perhaps running the risk of misinterpreting the data with respect to percentages of those who use condoms in order to prevent AIDS, if we say that in 90 percent of the cases, it's effective? Somehow or another, the public may get the idea that of those who use condoms, 90 percent will not get AIDS. That's one interpretation that could take place.

I think the correct way of phrasing it really is that every time you have sex, you have a 10 percent chance—every time you have sex with a condom, you have a 10 percent chance, or whatever the percentage is, of not having it be successful to prevent the transmissibility of a fatal disease.

Isn't that the correct way to express it?

Mr. ROSENBERG. Well, not exactly. The probability is a function that comes about from a very large study population. So on an individual basis, maybe a little bit loose, but perhaps not too far off to say that.

I think your point about misinterpretation of these statistics, though, to me at least, underscores the need for education. I think that's—I mean, as I look at, as I hear what's been said this morning and as I looked at the data in preparation for this, what I've spoken this morning, I think the first imperative that we face is very clear, and that's one of education. I mean, we know some things that can help to save lives, and that's got to be the first thing we do.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you both for your testimony today. It's been very helpful to us.

Ms. CRENSHAW. May I make one last comment very briefly?

Mr. WAXMAN. Very briefly.

Ms. CRENSHAW. I'm feeling a little schizophrenic today, because as a sex educator, having helped to usher in the sexual revolution, I now find myself making, for medical reasons, very conservative comments.

Because of this internal experience that I have endured over these last number of years that we've been fighting the AIDS epidemic, I do see solutions for both the liberal left and the conservative right and meet eye to eye and pull together better than I've observed them doing during this epidemic. And I don't think that the recommendations that we pursue need to continue to be so polarized.

The right needs to understand that condoms will be a second-string mainstay of this epidemic and sex education in the schools, even though it makes them uncomfortable. And the left needs to be a little more tolerant of more exclusive sexual relationships, or the conservative right is all society will be left with by natural selection. So I hope they pull together and work a little better in a nonpartisan fashion.

Mr. WAXMAN. First of all, you assume that people who espouse a particular point of view follow that view themselves in their own lives.

Ms. CRENSHAW. That's a good point.

Mr. WAXMAN. But let me express to you my understanding and strong feeling that we're not talking about, in public health measures and particularly fighting this epidemic, something where the political lines of Democrat versus Republican or left versus right makes any sense.

Our total commitment has to be to stop the spread of this disease. If you just look at the recommendations from the Reagan administration, which most people would consider politically conservative, and even those of Dr. Koop, who is considered quite conservative in his own political points of view, you see a consensus from these public health people as to what will be effective. We need those points of view expressed, and we need to follow them out and not be blinded by rhetoric and moralistic preachings to do what is in the public health interest.

Thank you. That concludes our meeting. We stand adjourned.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]